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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01274

1336 **CERTIFICATE OF DEATH**Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>1yr. 7mos. 29days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>844 Carey Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Fred</u> <u>Abrams</u>				<u>2</u> <u>5</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Separated</u>	<u>7/6/83</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>- - -</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Virgle B. Abrams</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Hawkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Unknown</u> <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>- - -</u>		<u>- - -</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>- - -</u>		<u>- - -</u>		<u>- - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>- - -</u>		<u>- - -</u>		<u>- - -</u>			
22. I hereby certify that I attended the deceased from <u>6/7</u> , 19 <u>54</u> , to <u>2/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>56</u> , and that death occurred at <u>6:05p</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>2/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>EB 8 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>1348 N. Calhoun St</u>	

1. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

57

2000

BUREAU V. S.

1952 FEB 9

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

01275

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis</u>				TOWN <u>Edgewater</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A. C. Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Southdown Shores</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM Melville AITCHISON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2 2 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Aug. 14, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Army</u>		11. BIRTHPLACE (State or foreign country) <u>Oil City, Pa.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Aitchison</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES Discharged 8/22/1919</u>				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <u>Mrs. Janet N. Aitchison, Wife</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Edgewater, Md.</u>		INTERVAL BETWEEN ONSET AND DEATH	
430.0 IMMEDIATE CAUSE (A) <u>Pulmonary Congestion</u>						3-4 HRS	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Bacterial Endocarditis</u>						11 DAYS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HEMICLYTIC STAPHYLOCOCCUS AUREUS</u>						11 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/22</u> , 19 <u>56</u> , to <u>2/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>56</u> , and that death occurred at <u>11:14</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Edward A Beck</u>		M.D. <u>44 Southgate Ave Annapolis</u>		DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/6/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. D. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gumbert's Son</u>		ADDRESS <u>1756 Pa. Ave., N.W. Wash., D.C.</u>	
DATE <u>Feb. 6, 1956</u>							

# CERTIFICATE OF DEATH

1850

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF OFFICE

22. SIGNATURE OF DEPARTMENT

23. SIGNATURE OF BUREAU

24. SIGNATURE OF RECORDS

25. SIGNATURE OF INDEX

26. SIGNATURE OF STATISTICS

27. SIGNATURE OF VITALS

28. SIGNATURE OF MORTALITY

29. SIGNATURE OF MARRIAGE

30. SIGNATURE OF DIVORCE

31. SIGNATURE OF ADULTERY

32. SIGNATURE OF FRAUD

33. SIGNATURE OF PERJURY

34. SIGNATURE OF OBSCURITY

35. SIGNATURE OF IGNORANCE

36. SIGNATURE OF MISERY

37. SIGNATURE OF DEATH

38. SIGNATURE OF LIFE

39. SIGNATURE OF SUFFERING

40. SIGNATURE OF PAIN

41. SIGNATURE OF GRIEF

42. SIGNATURE OF LOSS

43. SIGNATURE OF SADNESS

44. SIGNATURE OF REGRET

45. SIGNATURE OF REMORSE

46. SIGNATURE OF GUILT

47. SIGNATURE OF CONSCIENCE

48. SIGNATURE OF PRIDE

49. SIGNATURE OF ENVY

50. SIGNATURE OF JEALOUSY

51. SIGNATURE OF WRATH

52. SIGNATURE OF VIOLENCE

53. SIGNATURE OF REVENGE

54. SIGNATURE OF HATRED

55. SIGNATURE OF BLOOD

56. SIGNATURE OF FIRE

57. SIGNATURE OF WAR

58. SIGNATURE OF PEACE

59. SIGNATURE OF LOVE

60. SIGNATURE OF HATE

61. SIGNATURE OF LIFE

62. SIGNATURE OF DEATH

63. SIGNATURE OF SUFFERING

64. SIGNATURE OF PAIN

65. SIGNATURE OF GRIEF

66. SIGNATURE OF LOSS

67. SIGNATURE OF SADNESS

68. SIGNATURE OF REGRET

69. SIGNATURE OF REMORSE

70. SIGNATURE OF GUILT

BUREAU V. 8

FEB 7 1956

RECEIVED

NOTIFICATION

1. This is to certify that the above named person has died at the place and on the date stated above, and that the cause of death is as stated above. This certificate is to be used for the purpose of obtaining a burial permit from the health department. It is to be filled out by the physician or other person who has attended the deceased, and it is to be signed by the physician or other person who has attended the deceased. It is to be filed in the office of the registrar of vital statistics, and it is to be made available to the public for inspection. It is to be kept for a period of ten years, and it is to be destroyed after that period. It is to be used for the purpose of obtaining a burial permit from the health department. It is to be filled out by the physician or other person who has attended the deceased, and it is to be signed by the physician or other person who has attended the deceased. It is to be filed in the office of the registrar of vital statistics, and it is to be made available to the public for inspection. It is to be kept for a period of ten years, and it is to be destroyed after that period.

1

## CERTIFICATE OF DEATH

Item 8, Film G194 3-13-56 et

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2mos. 14 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westover</u>		<u>19x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None listed</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Maggie</u> (First) <u>Armwood</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2</u> <u>28</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MAR 12-1898</u>	9. AGE last birthday <u>58?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Wesley Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Mirrha Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-0145675</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>since 12/14/55</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION - - - - -		19b. MAJOR FINDINGS OF OPERATION - - - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) - - - - - M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? - - - - -			
22. I hereby certify that I attended the deceased from <u>12/14</u> , 19 <u>55</u> , to <u>2/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/28</u> , 19 <u>56</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Heleynard Heard Keissner M.D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>2/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Westover Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westover Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Maryland</u>	

MAR 5 1956

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

01830

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. DATE OF BIRTH (Month, Day, Year)

4. OCCUPATION

5. PLACE OF BIRTH

6. NAME OF PHYSICIAN

7. NAME OF HOSPITAL

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

MAR 15-1898

814-1-5572

BUREAU V. 51

MAR 6 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1301

01277  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 21

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1108 Eastport Terrace</u>				STREET ADDRESS (If rural, give location) <u>1108 Eastport Terrace</u>			
<b>3. NAME OF DECEASED:</b> (First) <u>HARRY</u> (Middle) <u>ATHANAS</u> (Last) _____				<b>4. DATE OF DEATH</b> (Month) <u>FEBRUARY</u> (Day) <u>14</u> (Year) <u>19 56</u>			
<b>5. SEX:</b> <u>Male</u>		<b>6. COLOR OR RACE:</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Married</u>		<b>8. DATE OF BIRTH:</b> <u>January 1, 1909</u>	
				<b>9. AGE last birthday:</b> <u>47 yrs.</u>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Manager</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Lunch Room</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Greece</u>			
<b>13. FATHER'S NAME:</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		<b>16. SOCIAL SECURITY No.:</b> <u>219-16-0684</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Violet Athanas- Wife- same as # 2</u>			

<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						<u>under</u>	
<b>Immediate cause</b> (a) <u>Heart Disease</u> DUE TO <b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u> stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>				<b>20. AUTOPSY:</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)</b> <u>Home</u>		<b>21c. (City or town)</b> <u>Annapolis</u> (County) <u>Anne Arundel</u> (State) <u>Maryland</u>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>February 14, 56 am.</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>Natural causes</u>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <u>Elmer G. Link</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>Feb. 14, 56</u> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>					
<b>23. BURIAL, CREMATION, REMOVAL, (Specify):</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 17, 56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Glen Burnie, Maryland</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>Feb. 15, 1956</u>		<b>REGISTER'S SIGNATURE</b> <u>[Signature]</u>		<b>24. FUNERAL DIRECTOR</b> <u>Hopping and Kirkley Funeral Home</u> <u>Glen Burnie, Maryland</u>			

RECEIVED

FEB 17 1956

BUREAU V. S.

13-2  
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1105 Poplar Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD OWEN BASSFORD</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 22 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1901</u>		9. AGE (In years lost birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mach.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Harwood, Anne Arundel, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James H. Bassford</u>				14. MOTHER'S MAIDEN NAME <u>Mammie Asquith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs Ottie Worley Bassford, Wife- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 6, 1954</u> to <u>Feb. 22, 1956</u> , that I last saw the deceased alive on <u>2/22/56</u> , and that death occurred at <u>4:28</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>2/24/56</u> ACTUAL SIGNATURE <u>James R. Martin</u> M.D. <u>James R. Martin</u> PHYSICIAN'S NAME (Type) <u>Dr. James Martin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 25, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>DATE 2-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>V. Douch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and camp are to be filled in by the funeral director. Pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the attending physician and camp, the funeral director should file the certificate with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 27 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01280

## 1337 CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Pasadena</i>				TOWN <i>Pasadena</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mill Rd. @ O. Annapolis Rd.</i>				STREET ADDRESS (If rural give location) <i>Mill Rd. @ O. Annapolis Blvd.</i>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Willard Benton</i>				<i>Feb 7 1956</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Aug. 29, 1872</i>	<i>83</i>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Laborer (ret.)</i>		<i>Co-Road Con.</i>		<i>Hartford Conn., Md.</i>		<i>U.S.A.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Leonard Benton</i>				<i>Martha Knight</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<i>No</i>		<i>Unknown</i>		<i>Mrs. Vivian M. Holland 527 Mandel 3 Klyn 25 14d</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>434.1 IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<i>Congestive Heart Failure</i>						<i>6 yrs.</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>			<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>		
			White <input type="checkbox"/> Not white <input type="checkbox"/>				
			M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>				
<b>22. I hereby certify that I attended the deceased from Feb. 14, 1956, to Feb. 7, 1956, that I last saw the deceased alive on Feb. 7, 1956, and that death occurred at 1:55 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<i>R. M. McLaughlin</i>				<i>RFD 6 Box 372 Pasadena Md.</i>		<i>Feb 8, 1956</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>				<i>Meddewidge Mem. Pk.</i>		<i>Howard Co., Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Feb. 11, 1956</i>		<i>L. J. DeAlba</i>		<i>L. J. DeAlba</i>		<i>Colon B. Burnie, Md.</i>	

RECEIVED  
FEB 11 1955

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01281

## 1303 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Churchton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES</u> (First) <u>Blunt</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb 14</u> 19 <u>56</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Dec 1 1883</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hauling</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Churchton Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>William Blunt</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>213-347275</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Alma Blunt, Churchton Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>491X</b> IMMEDIATE CAUSE (A) <u>atypical acute pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2-14-56</u>, 19<u>56</u>, to <u>2-14-56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2-14-56</u>, 19<u>56</u>, and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Ans T. Allen</u>		<b>DATE THEREOF</b> <u>Feb 17 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Franklin</u>		<b>LOCATION (City, town, or county)</b> <u>Churchton Md</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Hardisty</u>		<b>ADDRESS</b> <u>Belleville Md</u>	
<b>DATE</b> <u>MAR 5 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Thos J. French</u>					

# 1908 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

100-000-000

1. Name of deceased (print or write)

2. Place of death

3. Date of death  
4. Time of death  
5. Age of deceased at death  
6. Sex of deceased  
7. Race of deceased  
8. Marital status of deceased  
9. Occupation of deceased  
10. Cause of death (print or write)

11. Signature of attending physician (print or write)  
12. Signature of registrar (print or write)

13. Signature of informant (print or write)  
14. Signature of registrar (print or write)

15. Signature of registrar (print or write)  
16. Signature of registrar (print or write)

17. Signature of registrar (print or write)  
18. Signature of registrar (print or write)

19. Signature of registrar (print or write)  
20. Signature of registrar (print or write)

21. Signature of registrar (print or write)  
22. Signature of registrar (print or write)

23. Signature of registrar (print or write)  
24. Signature of registrar (print or write)

25. Signature of registrar (print or write)  
26. Signature of registrar (print or write)

27. Signature of registrar (print or write)  
28. Signature of registrar (print or write)

29. Signature of registrar (print or write)  
30. Signature of registrar (print or write)

31. Signature of registrar (print or write)  
32. Signature of registrar (print or write)

33. Signature of registrar (print or write)  
34. Signature of registrar (print or write)

RECEIVED

MAR 5 1956

BUREAU V. S.

100-000-000

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1338 **CERTIFICATE OF DEATH**

01282

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Glen Burnie</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Fourth Ave., S.E.</u>				STREET ADDRESS <u>100 Fourth Ave., S.E.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ANNA</u> (Middle) <u>Louise</u> (Last) <u>BROMWELL</u>				(Month) <u>FEB</u> (Day) <u>1</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b> <u>28 Nov. 1876</u>	
<b>9. AGE last birthday</b> <u>79</u> yrs.		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE (State or foreign country)</b> <u>Richmond, Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>housework (ret)</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>			
<b>13. FATHER'S NAME</b> <u>Greener</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilhelmina Siljacks</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Laura Bosley - 100 Fourth Ave., Glen Burnie</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>443X IMMEDIATE CAUSE (A)</b> <u>CARDIAC DECOMPENSATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>10/7</u>, 19<u>50</u>, to <u>2/1</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/31</u>, 19<u>56</u>, and that death occurred at <u>7 A</u>.M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Bobby L. Jones</u> M.D.				<b>ADDRESS (Street, city, town, state)</b> <u>Glen Burnie, Md.</u>		<b>DATE SIGNED</b> <u>2/1/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 4/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>London Park</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>L. J. DeAlba</u>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>T. King</u>		<b>ADDRESS</b> <u>Glen Burnie, Md.</u>	
<b>DATE</b> <u>Feb 7, 1956</u>							

# CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INVESTIGATOR

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF STATE ATTORNEY

24. SIGNATURE OF ATTORNEY GENERAL

25. SIGNATURE OF SECRETARY OF STATE

26. SIGNATURE OF COMMISSIONER OF HEALTH

27. SIGNATURE OF DEPUTY COMMISSIONER

28. SIGNATURE OF ASSISTANT COMMISSIONER

29. SIGNATURE OF CHIEF CLERK

30. SIGNATURE OF CLERK

31. SIGNATURE OF RECEPTIONIST

32. SIGNATURE OF MAIL ROOM

33. SIGNATURE OF TELEPHONE ROOM

34. SIGNATURE OF RECORDS SECTION

35. SIGNATURE OF IDENTIFICATION SECTION

36. SIGNATURE OF LABORATORY

37. SIGNATURE OF RADIOLOGY

38. SIGNATURE OF PATHOLOGY

39. SIGNATURE OF BACTERIOLOGY

40. SIGNATURE OF VIROLOGY

41. SIGNATURE OF IMMUNOLOGY

42. SIGNATURE OF EPIDEMIOLOGY

43. SIGNATURE OF PUBLIC HEALTH

44. SIGNATURE OF COMMUNITY HEALTH

45. SIGNATURE OF SCHOOL HEALTH

46. SIGNATURE OF OCCUPATIONAL HEALTH

47. SIGNATURE OF ENVIRONMENTAL HEALTH

48. SIGNATURE OF NUTRITION

49. SIGNATURE OF PHYSICAL EDUCATION

50. SIGNATURE OF RECREATION

51. SIGNATURE OF ARTS AND CRAFTS

52. SIGNATURE OF MUSIC

53. SIGNATURE OF THEATRE

54. SIGNATURE OF FILM

55. SIGNATURE OF TELEVISION

56. SIGNATURE OF RADIO

57. SIGNATURE OF PRESS

58. SIGNATURE OF OTHER MEDIA

BUREAU V. 2

FEB 8 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01283

## 1839 CERTIFICATE OF DEATH

Reg. Dist. No. 2D

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Riva</u>				TOWN <u>Riva</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
23				1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>RANDALL</u> (Middle) <u>A</u> (Last) <u>BUTLER</u>				FEBRUARY 4		19 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	April 5, 1874	81 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Farmer		Own farm		Davidsonville, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Butler				Jeanette A. Starlings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Mrs Addie Butler- Wife- same as # 2			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>i hypertension</u>			
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Feb 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>56</u> , and that death occurred at <u>9:07</u> M, from the causes and on the date stated above.							
SIGNATURE <u>S. B. Brown</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>2/6/56</u>	
M.D. <u>Annapolis Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Feb. 7, 56		Cedar Hill Cemetery		Anne Arundel County, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-6-56</u>		<u>Edward Collins</u>		<u>HOPKINS FUNERAL HOME</u>		ANNAPOLIS, MD.	



1394

## CERTIFICATE OF DEATH

01284

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLSWORTH</u> Middle <u>C.</u> Last <u>BURT</u>				4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIFE INSURANCE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Span-American</u>		17. INFORMANT <u>Edith B. Burt</u>		Address <u>BURUSIDE ST. #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Feb 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4221st</u> DATE SIGNED <u>4221st</u>							
ACTUAL SIGNATURE <u>S. Boerssue</u> M.D. <u>Ameyroler</u>				PHYSICIAN'S NAME (Type) <u>S. Boerssue</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. 77th + Ave</u>				ADDRESS <u>ANNAPOLIS, MD.</u>		24a. REC'D BY REGISTRAR <u>423/1956</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

**BUREAU V.**

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01285

## 1340 CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH COUNTY <u>St. Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> TOWN <u>Bristol</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>St. Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> TOWN <u>Bristol</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Richard</u> (First) <u>Butler</u> (Last) 4. DATE OF DEATH <u>Feb. 16</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>May 9</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Bristol</u>
13. FATHER'S NAME <u>David Butler</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Johnnie Butler</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u>Today</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Feb. 1956</u> to <u>16 Feb. 1956</u> , that I last saw the deceased alive on <u>14 Feb. 1956</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>R B Jasser</u> M.D.		ADDRESS (Street, city, town, state) <u>Upper Marlboro Md</u> DATE SIGNED <u>Feb 16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Feb 20/56</u>	NAME OF CEMETERY OR CREMATORY <u>Moses</u>	LOCATION (City, town, or county) (State) <u>Durham Ind</u>
24. REC'D BY REGISTRAR <u>FEB 27 1956</u>	REGISTRAR'S SIGNATURE <u>Eda Belle Dent</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Annie A. Johnson</u>	ADDRESS <u>Annapolis, Md.</u>

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.  
**CERTIFICATE OF DEATH**

Part One of

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		TIME OF BIRTH [Faint handwritten time]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
PLACE OF DEATH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
NAME OF PHYSICIAN [Faint handwritten name]		NAME OF CLERIC [Faint handwritten name]		NAME OF MINISTER [Faint handwritten name]	
NAME OF BURIAL PLACE [Faint handwritten name]		NAME OF FUNERAL HOME [Faint handwritten name]		NAME OF CEMETERY [Faint handwritten name]	

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		TIME OF BIRTH [Faint handwritten time]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
PLACE OF DEATH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
NAME OF PHYSICIAN [Faint handwritten name]		NAME OF CLERIC [Faint handwritten name]		NAME OF MINISTER [Faint handwritten name]	
NAME OF BURIAL PLACE [Faint handwritten name]		NAME OF FUNERAL HOME [Faint handwritten name]		NAME OF CEMETERY [Faint handwritten name]	

**BUREAU A. S.**  
 FEB 27 1956  
**RECEIVED**

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.  
 This is a copy of the original certificate of death filed in the office of the Registrar of Vital Statistics, State of Massachusetts, and is not to be used for any other purpose.  
 It is the duty of the Registrar to issue a copy of this certificate to the family of the deceased, and to the funeral home or other person in charge of the funeral, and to the cemetery where the body is interred.  
 The original certificate of death is filed in the office of the Registrar of Vital Statistics, State of Massachusetts, and is not to be used for any other purpose.  
 It is the duty of the Registrar to issue a copy of this certificate to the family of the deceased, and to the funeral home or other person in charge of the funeral, and to the cemetery where the body is interred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01286

1395

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>				d. STREET ADDRESS <u>Annapolis, Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Elmira</u> Middle <u>Campbell</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1875</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob Rindell</u>			
14. MOTHER'S MAIDEN NAME <u>Miriam Ennis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>Frank Peters - 7 Parale St. Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nemia bron</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-Vascular Disease</u> DUE TO <u>B9</u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2/9/56</u> , 19 <u>  </u> , to <u>2/23/56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>2/23/56</u> , 19 <u>  </u> , and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert S. Johnson M.D.</u>				ADDRESS (Street, city or town, state) <u>37 Robert Street, Annapolis Md</u>			
DATE SIGNED <u>2/25/56</u>				PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-26-56</u>		<u>Fowlers</u>		<u>Best State Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - 108 W. Wash. St. Annapolis Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>2-29-1956</u>	
24b. REGISTRAR'S SIGNATURE <u>U. J. Smith</u>							

BUREAU V. S.

MAR 2 1951

RECEIVED

CERTIFICATE OF DEATH

1951

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is partially filled with handwritten text.

Bottom section of the form, likely for administrative use, including fields for registration number and date of registration.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C-455 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1396

## CERTIFICATE OF DEATH

01287

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Q. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Q. A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>601 Monterey Ave</u>				<u>19</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>WALTER SCOTT CLEVENGER</u>				<u>2-18-1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1-18-1891</u>	<u>65</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Engineer</u>		<u>U.S. Navy Academy</u>		<u>Phila. Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Clevenger</u>				<u>Clara Gonaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Elizabeth G. Clevenger</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.0 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-17-1956</u> to <u>2-18-1956</u> , that I last saw the deceased alive on <u>2-17-1956</u> , and that death occurred at <u>8:25</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James D. Smith</u>				DATE SIGNED <u>2/18/56</u>			
M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>2-19-56</u>		<u>St. Peter's Cemetery</u>		<u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 20 1956</u>		<u>J. D. Smith</u>		<u>John M. Schuler Sons</u>		<u>Annapolis, Md.</u>	

# CERTIFICATE OF DEATH

Reg. Dist. 18A

1. Name of Deceased

2. Date of Death

3. Time of Death

4. Place of Death

5. Age

6. Sex

7. Race

8. Occupation

9. Cause of Death

10. Manner of Death

11. Signature of Physician

12. Signature of Registrar

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Health Officer

16. Signature of Burial Officer

17. Signature of Undertaker

18. Signature of Funeral Home

19. Signature of Cemetery

20. Signature of Burial

21. Signature of Interment

22. Signature of Burial

23. Signature of Interment

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BUREAU V. S.

FEB 23 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01288

## 1341 CERTIFICATE OF DEATH

Reg. Dist. No. 28 28

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>old Annapolis Rd.</u>				STREET ADDRESS (If rural give location) <u>Old Annapolis Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>LEONARD</u> (Middle) <u>W</u> (Last) <u>GOALE</u>				(Month) <u>FEBRUARY</u> (Day) <u>8</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 31, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Robert Coale- Son same as # 2.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Years</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Oct</u>, 19<u>46</u>, to <u>Feb 8</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 6</u>, 19<u>56</u>, and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above.</b>							
SIGNATURE <u>Edward G. Shemett</u>		M.D. <u>Gambrells Md</u>		ADDRESS (Street, city, town, state) <u>2-9-56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cemet</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>2-11-56</u>		REGISTRAR'S SIGNATURE <u>K. M. Ye</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, MD.</u>			

# CERTIFICATE OF DEATH

11588

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1914 FEB 21

1. Name of deceased (Print or Write)

2. Date of death (Print or Write)

3. Place of death (Print or Write)

4. Sex (Print or Write)

5. Age (Print or Write)

6. Usual residence (Print or Write)

7. Cause of death (Print or Write)

8. Duration of illness (Print or Write)

9. Name of physician (Print or Write)

10. Name of informant (Print or Write)

11. Signature of informant (Print or Write)

12. Signature of physician (Print or Write)

13. Signature of registrar (Print or Write)

14. Name of registrar (Print or Write)

15. Signature of registrar (Print or Write)

16. Signature of registrar (Print or Write)

17. Signature of registrar (Print or Write)

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BUREAU V. S.

FEB 21 1914

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1342

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Kentucky</u>		COUNTY <u>Hardin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort G.G. Meade, Md.</u>		<u>5 Months</u>		TOWN <u>Cecilia</u>		<u>55x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #2 Box 90</u>			
3. NAME OF DECEASED (Type or Print) <u>SHARON KAY CONNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 13 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>9 February 1956</u>	9. AGE last birthday <u>4</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Delmar Ried Conner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Basham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother: R 1 Box 2, Fairfield, Va.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>4 Days</u>			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Prematurity (40 weeks)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>prematurity (40 wks?)</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 Feb</u> , 19 <u>56</u> , to <u>13 Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>13 Feb</u> , 19 <u>56</u> , and that death occurred at <u>105 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Said H. Tarabishy</u>				DATE SIGNED <u>13 Nov 55</u>			
ADDRESS (Street, city, town, state) <u>Fort G. G. Meade, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>—</u>		LOCATION (City, town, or county) (State) <u>Virginia, Timberridge</u>	
24. REC'D BY REGISTRAR <u>WILLIAM L. SAYLOR, 1ST LT MSC</u>		REGISTRAR'S SIGNATURE <u>—</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>			
DATE <u>13 Feb 56</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

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FEB 15 1956

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FEB 15 1956

## MARYLAND STATE DEPARTMENT OF HEALTH

01290

1343

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERSReg. Dist. No. 2/

1. PLACE OF DEATH- COUNTY <u>D. C.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stream Grove Road</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William</u> <u>Edward</u> <u>Date</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> - <u>1</u> - <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (S) <u>Single</u>	8. DATE OF BIRTH <u>May 25<sup>th</sup> 1903</u>
9. AGE last birthday <u>52</u> yrs.		10. If under 1 year Months Days Hours Mfn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Field N. J.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Date</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Kromenaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) - If yes, give war or dates of service <u>World War II Army</u>		16. SOCIAL SECURITY NO. <u>Douglas G. Date</u>	
17. INFORMANT AND ADDRESS <u>Watt Orange N. J.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>973.1</u> (a) Immediate cause <u>Carbon Monoxide</u> (b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Highway</u> (CITY OR TOWN) <u>D.C.</u> (COUNTY) <u>Dist</u> (STATE) <u>DC</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>1</u> <u>56</u> <u>A.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Garage door connected to Exhaust</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . SIGNATURE <u>John H. East</u> (Degree or title) <u>MD</u> ADDRESS <u>Unpublished</u> DATE SIGNED <u>4/2/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>2-3-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince Geo Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 3, 1956</u>		24. FUNERAL DIRECTOR <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01291

## 1307 CERTIFICATE OF DEATH

Items 13, 14 Film 194 3-23-56 et

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN <u>Annapolis</u>		<u>4 days</u>		TOWN <u>Shady Side</u>		<u>8</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel Gen. Hosp</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Florence Davis</u>				<u>Feb 29 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>	<b>11. IF UNDER 24 HRS.</b>	
<u>F</u>	<u>C</u>	<u>(Specify)</u>	<u>June 1, 1882</u>	<u>73</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<u>House Maid</u>		<u>Domestic</u>		<u></u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Unknown</u>				<u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<u>Coronary Occlusion</u>				<u>16 hrs</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>				<b>3 Years</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>1 Year</b>			
<b>DUE TO (C)</b>				<b>2 weeks</b>			
<u>Generalized Arteriovascular Disease</u>				<u>1 year</u>			
<u>Beri Beri Heart Disease</u>				<u>2 weeks</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>20. AUTOPSY?</b>			
<u>Urinary tract infection</u>				<b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
<u>Congestive Failure</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 19 1954</u>, to <u>Feb 19 1956</u>, that I last saw the deceased alive on <u>2/28</u>, 19 <u>56</u>, and that death occurred at <u>5:00 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>F.D. Hendrick</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Shady Side, Maryland</u>		<b>DATE SIGNED</b> <u>3/3/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>3/3/56</u>		<u>Chews</u>		<u>West River, Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Mar. 5, 1956</u>		<u>F.D. Hendrick</u>		<u>Buried Hendrick</u>		<u>Gilwell</u>	

# 1907 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. 100-10

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

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BUREAU V. 3

MAR 7 1906

RECEIVED

MASSACHUSETTS

RECEIVED  
MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON  
MAR 7 1906

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01292

## 1398 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY <u>D.C.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>churchton</u> <u>Rural</u> <u>X</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS <u>Broadwater</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNAPOLIS GENERAL HOSPITAL</u>							
3. NAME OF DECEASED (Type or Print) <u>SUSIE MAUDE DONALDSON</u>				4. DATE OF DEATH <u>2</u> <u>6</u> <u>56</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Aug 22, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hooover</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Harry S. Donaldson, m.d. churchton, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						12th	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Bronchial Asthma (history)</u>						yes	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, general</u>						yes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6/56</u> , to <u>2/6/56</u> , that I last saw the deceased alive on <u>2/6/56</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shuler</u>		DATE THEREOF <u>2-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Feb 10 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>Washington, D.C.</u>	



1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01293

1379 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>A. A. Co.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>A. A.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Annapolis</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pasadena</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Annapolis General Hosp.</b>				STREET ADDRESS (If rural give location) <b>Mt. Pleasant Beach</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Lewis W Ehlers</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 15, 1956</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>April 4, 1906</b>		<b>9. AGE last birthday</b> <b>49</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Barber</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Self Emp.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>L. Wilmer Ehlers</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Arnie Kelly</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>-</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Hattie Ehlers-Mt. Pleasant Beach</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>490X</b> IMMEDIATE CAUSE (A) <b>Lobar pneumonia RML</b>						<b>1 wk.</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Delirium Tremens</b>						<b>18 hrs.</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street-office-bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>2/13/56</b> , to <b>2/15/56</b> , that I last saw the deceased alive on <b>2/15/56</b> , and that death occurred at <b>4:45</b> P.M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Frank M. Slapley</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Annapolis, Md.</b>		<b>DATE SIGNED</b> <b>2/15/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/18/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cem.</b>		<b>LOCATION (City, town, or county)</b> <b>Balto., Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>FEB 17 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Wm. J. French</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. J. Tiekener &amp; Sons - Balto.</b>			



1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
V5 A15C 1-55 10M

1310 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Annapolis		LENGTH OF STAY (in this place) 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) Severna Park			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen				STREET ADDRESS (If rural, give location) Arnold Md			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY EMMA Fishpaw				4. DATE OF DEATH (Month) (Day) (Year) Feb 14 1956			
5. SEX F		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH Aug 3, 1875	
				9. AGE last birthday 80 yrs.		10. IF UNDER 1 YEAR Months Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Woodlawn Bkts		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME John Luther Jones				14. MOTHER'S MAIDEN NAME Martha Ann Remmey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Arnold, Md, Charles Fishpaw	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Heart Failure				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) MYOCARDIAL INFARCTION							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arteriosclerosis Generalized							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1956 to Feb 1956, that I last saw the deceased alive on Feb 1956, and that death occurred at 2:50 P.M. from the causes and on the date stated above.							
SIGNATURE R. Halpin				DATE SIGNED ADDRESS (Street, city, town, state) Severna Park Md 21156			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-15-56		NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		LOCATION (City, town, or county) Glen Burnie Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE J. J. Trunch		25. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		ADDRESS Annapolis Md	
DATE Feb. 15, 1956							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

01234

REG. DIST. NO.

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

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NOTIFICATION

1. This certificate is to be filled out by the attending physician or other qualified person who has attended the deceased during the last illness. It should be filled out as soon as possible after death, and should be signed by the attending physician or other qualified person who has attended the deceased during the last illness. It should be filed with the local health department or other authority having jurisdiction over the death. It should be filled out in duplicate, one copy to be filed with the local health department or other authority having jurisdiction over the death, and the other copy to be retained by the attending physician or other qualified person who has attended the deceased during the last illness.

BUREAU V. S.

FEB 17 1956

RECEIVED

24. FEDERAL DIRECTOR ADDRESS  
Hopping Funeral Home Annapolis, Md.

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1956

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01296

## 1311 CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10 Rural Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>57 U.S. Naval Hospital, Annapolis, Md.</u>				STREET ADDRESS (If rural give location) <u>Rt. 2 Box 122 Edgewater, Maryland</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Michael Thomas GOODRUM</u>				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>28 November 1955</u>	9. AGE last birthday yrs. <u>2</u> Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Adell Robert Lee Goodrum</u>				14. MOTHER'S MAIDEN NAME <u>Mazie Quick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>U.S. Naval Hospital, Annapolis, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
492x IMMEDIATE CAUSE (A) <u>Pneumonia, interstitial acute #763</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-5-</u> <u>1956</u> , <b>to</b> <u>2-5-</u> <u>1956</u> , <b>that I last saw the deceased</b> <b>alive on</b> <u>2-5-</u> <u>1956</u> , <b>and that death occurred at</b> <u>9:05 a.m.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>E.R. PETERS LCDR MC USN</u> <b>ADDRESS</b> (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> <b>DATE SIGNED</b> <u>2-6-56</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-7-56</u>		<u>Brewer Hill</u>		<u>Annapolis, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb. 7, 1956</u>		<u>W. J. Smith</u>		<u>William Reese</u>		<u>Annapolis, Md</u>	

2051235372



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1345 CERTIFICATE OF DEATH

01297

Reg. Dist. No. 201

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>KENT</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>BROOKLYN PARK</u> 6 YRS.		LENGTH OF STAY (in this place)		OR TOWN <u>STILL POND</u> 14X-2		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>132N. 2ND AVE.</u>							
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALETHIA - GOSMAN</u>				<u>FEB. 28 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>MAY 10, 1864</u>	<u>91</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>HOME</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN CAMPBELL</u>				<u>ELLEN MURRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>MAUDE BANNING BROOKLYN PK.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
794X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Senility</u>						<u>6mo.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>Feb. 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 27</u> , 19 <u>56</u> , and that death occurred at <u>5:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>J. J. Gurnall Jr.</u>		<u>4609 Gai. Ritchie Hwy. Balto 25 Md</u>		<u>2-28-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR. 3, 1956</u>		<u>I. O. CEMETERY</u>		<u>WORTON, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2/29/56</u>		<u>E. J. Kennedy</u>		<u>Victor N. Kennedy</u>		<u>STILL POND, MD.</u>	

# CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF VOTING CLERK

26. SIGNATURE OF SCHOOL CLERK

27. SIGNATURE OF CHURCH CLERK

28. SIGNATURE OF POST OFFICE CLERK

29. SIGNATURE OF RAILROAD CLERK

30. SIGNATURE OF AIRLINE CLERK

31. SIGNATURE OF BUS CLERK

32. SIGNATURE OF TRUCK CLERK

33. SIGNATURE OF TAXI CLERK

34. SIGNATURE OF RENTAL CLERK

35. SIGNATURE OF HOTEL CLERK

36. SIGNATURE OF RESTAURANT CLERK

37. SIGNATURE OF BAR CLERK

38. SIGNATURE OF NIGHT CLUB CLERK

39. SIGNATURE OF GAMING CLERK

40. SIGNATURE OF CASINO CLERK

41. SIGNATURE OF RACETRACK CLERK

42. SIGNATURE OF LOTTERY CLERK

43. SIGNATURE OF GAMING MACHINE CLERK

44. SIGNATURE OF GAMING MACHINE CLERK

BUREAU V. S.

MAR 17 1950

RECEIVED

2001700-20

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF DEATH  
10. TIME OF DEATH  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF WITNESSES  
14. SIGNATURE OF DECEASED  
15. SIGNATURE OF NEXT OF KIN  
16. SIGNATURE OF CLERGYMAN  
17. SIGNATURE OF BURIAL OFFICIAL  
18. SIGNATURE OF INTERVIEWER  
19. SIGNATURE OF CORONER  
20. SIGNATURE OF JURY  
21. SIGNATURE OF JUDGE  
22. SIGNATURE OF DISTRICT ATTORNEY  
23. SIGNATURE OF COUNTY CLERK  
24. SIGNATURE OF TOWNSHIP CLERK  
25. SIGNATURE OF VOTING CLERK  
26. SIGNATURE OF SCHOOL CLERK  
27. SIGNATURE OF CHURCH CLERK  
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30. SIGNATURE OF AIRLINE CLERK  
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33. SIGNATURE OF RENTAL CLERK  
34. SIGNATURE OF HOTEL CLERK  
35. SIGNATURE OF RESTAURANT CLERK  
36. SIGNATURE OF BAR CLERK  
37. SIGNATURE OF NIGHT CLUB CLERK  
38. SIGNATURE OF GAMING CLERK  
39. SIGNATURE OF CASINO CLERK  
40. SIGNATURE OF RACETRACK CLERK  
41. SIGNATURE OF LOTTERY CLERK  
42. SIGNATURE OF GAMING MACHINE CLERK  
43. SIGNATURE OF GAMING MACHINE CLERK  
44. SIGNATURE OF GAMING MACHINE CLERK

# MARYLAND STATE DEPARTMENT OF HEALTH

02456

1346

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 11, Film G194 3-22-56 et

1. PLACE OF DEATH- COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Jessups		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chrisfield	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland House of Correction		STREET ADDRESS (If rural, give location) 217 Tyler Street	
3. NAME OF DECEASED (Type or Print) James	(First)	(Middle)	(Last) Grant
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 9/16/1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 47 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James Grant, Sr.		14. MOTHER'S MAIDEN NAME Annie Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac failure

INTERVAL BETWEEN ONSET AND DEATH

1 month

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardia vascular heart disease with Nephritis

2 years

(c) Pulmonary Bilateral Tuberculosis

3 years

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/17, 1956, to 2/28, 1956, that I last saw the deceased

alive on 2/28, 1956, and that death occurred at 5:45 A. m., from the causes and on the date stated above.

SIGNATURE: Robert B. Taylor, M.D. (Degree or title) ADDRESS: Maryland House of Correction DATE SIGNED: 2/28/56

23. BURIAL, CREMATION REMOVAL (Specify) Entombed	DATE TIERED OFF 3/2/56	NAME OF CEMETERY OR CREMATORY Univ of Md. Med School	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 13 1956	REGISTRAR'S SIGNATURE Clara Taylor	24. FUNERAL DIRECTOR	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

MAR 14 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1312 CERTIFICATE OF DEATH

01298

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>Annapolis</u>				STREET ADDRESS		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
63 <u>AA General</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Frederick Albert Green</u>				(Month) (Day) (Year) <u>2-4-1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec 14-1879</u>	<u>76</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Truck</u>		<u>West Va</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Green</u>				<u>Martha Rotuck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		(2)	
				<u>Hattie B. Green</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
416X IMMEDIATE CAUSE (A) <u>Pulmonary embolism L45.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Mural thrombosis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatic-arteriosclerotic heart d.</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastritis + anthracosis</u>				<u>yes.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>2/4/56</u> , that I last saw the deceased alive on <u>2/4/56</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shuply</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>2/8/56</u>	
M.D. <u>Annapolis</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-8-56</u>		<u>Lahmansville W. Va</u>		<u>Lahmansville W. Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 6, 1956</u>		<u>J. J. Pouch</u>		<u>John M. Taylor Sons</u>		<u>Annapolis Md</u>	

# CERTIFICATE OF DEATH

1956

12

1. PLACE OF BIRTH

2. PLACE OF DEATH

3. SEX  
4. AGE  
5. OCCUPATION  
6. MARITAL STATUS

7. CAUSE OF DEATH

8. DATE OF DEATH  
9. TIME OF DEATH  
10. PLACE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF SHERIFF

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82. SIGNATURE OF SHERIFF

BUREAU V. A.

FEB 7 1956

RECEIVED

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TO DIRECTOR, MARYLAND STATE DEPARTMENT OF HEALTH

TO DIRECTOR, MARYLAND STATE DEPARTMENT OF HEALTH

Item 18 Film G193 3-13-56 and

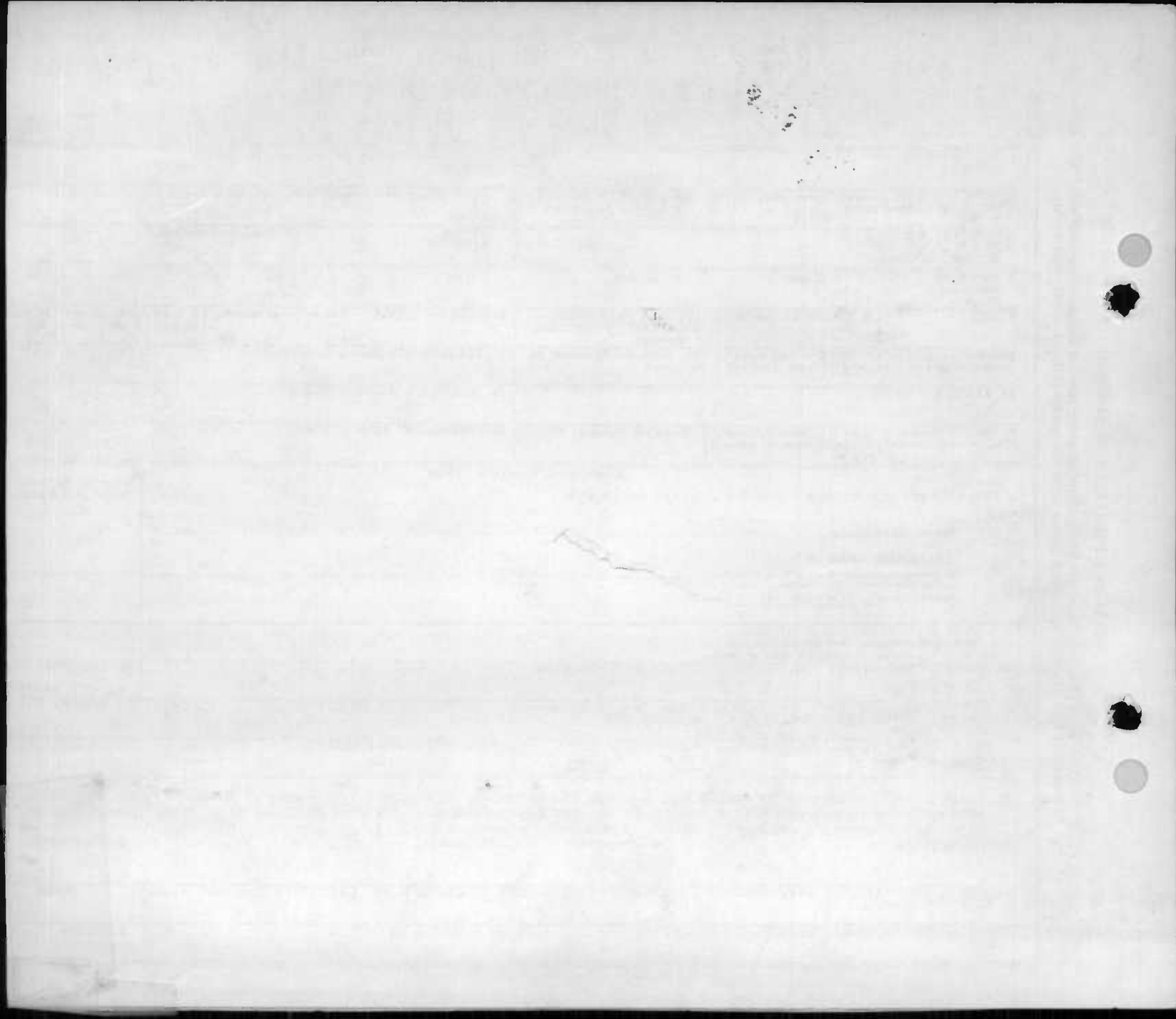
# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

THIS IS A PERMANENT RECORD.  
PLEASE TYPE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg

1. NAME OF DECEASED (Type or Print) <b>ALFRED B. HAUPT</b>			2. DATE OF DEATH <b>2-23-56</b>		
3. PLACE OF DEATH: <b>3 M. N. of Odenton Station</b> <b>A. Baltimore City, Maryland on P.R.R.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) <b>A. STATE Maryland</b> <b>B. COUNTY</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Anne Arundel County</b>			6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
7. Length of stay in Baltimore <b>03</b>			8. STREET ADDRESS (If rural, give location) <b>201 Tuscany Road Carden Apts.</b>		
9. SEX <b>Male</b>	10. COLOR OR RACE <b>White</b>	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	12. DATE OF BIRTH <b>Dec. 30, 1888</b>	13. AGE (In years last birthday) <b>67</b>	14. If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>			16. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		
17. FATHER'S NAME <b>Alfred Haupt</b>			18. MOTHER'S MAIDEN NAME <b>Eleonora Boucsein</b>		
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>			20. SOCIAL SECURITY NO. <b>none</b>		
21. World War No. <b>1</b>			22. INFORMANT ADDRESS <b>Mrs. Emma J. Haupt - Garden Apts.</b>		
18. <b>801X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Crushing injuries of head, chest and abdomen with traumatic evisceration of abdominal contents and brain.</b>			INTERVAL BETWEEN ONSET AND DEATH		
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Train derailed: 2-23-56 5:26 P.M.</b>			24. Injury occurred 3 miles north of Odenton Station P.R.R.		
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			26. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		
27. 19A. DATE OF OPERATION			28. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
29. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			30. 23A. SIGNATURE <b>William J. Dickner</b>		
31. 23B. CHIEF MEDICAL EXAMINER... ASSISTANT MEDICAL EXAMINER... MEDICAL INVESTIGATOR			32. 23C. DATE SIGNED <b>2-24-56</b>		
33. 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	34. 24B. DATE <b>2/25/56</b>	35. 24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	36. 24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		
37. DATE RECEIVED BY LOCAL REGISTRAR <b>February 25, 1956</b>			38. REGISTRAR'S SIGNATURE <b>R.W.</b>		
39. 25. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons - Balto.</b>			40. ADDRESS		



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01300

21

Reg. Dist. No. ....

## 1348 CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A.Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN				Pasadena		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>D.O.A. EN ROUTE Anne Arundel Gen. Hosp.</u>				STREET ADDRESS (If rural give location): <u>Railroad Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DORA</u> (Middle) <u>Hayden</u> (Last)				2 5 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white	married	4-10-02	53 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Refectory worker (ret.) Am. Blind Assn.</u>		<u>Am. Blind Assn.</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>(unknown) Worley</u>				<u>Gertrude (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>(blank)</u>		<u>Paul Hayden Pasadena, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
936.8 IMMEDIATE CAUSE (A) <u>Embolus, pulmonary, massive</u>						few hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>postoperative complication, surgical</u>						13 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Old &amp; recent injury, ext. lacerations, at knee</u>						15 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Adiposities</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1-23-56		old & recent injury, lateral meniscus, Right Knee					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		<u>on bus</u>		<u>Pasadena, A.A.Co. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
1-25-56 M.				<u>Self-accidental, in kicking seat up</u>			
22. I hereby certify that I attended the deceased from Jan 22, 1956, to Feb 5, 1956, that I last saw the deceased alive on Jan 28, 1956, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Menton T. White</u> M.D. <u>Cathedral &amp; Dean Sts. Annapolis Md.</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 9, 1956</u>		<u>Glen Haven</u>		<u>Glen Burnie</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 14, 1956</u>		<u>John J. French</u>		<u>TR Sengle</u>		<u>Glen Burnie, Md.</u>	

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10

EB 17 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1349 CERTIFICATE OF DEATH

01301

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>208 Annapolis Blvd NW</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u> STREET ADDRESS (If rural give location) <u>208 Annapolis Blvd NW</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>Arthur</u> (Last) <u>Headley</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 9, 1875</u>
9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>—</u> (Days) <u>—</u> IF UNDER 24 HRS. (Hours) <u>—</u> (Min.) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lulus Headley</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA VAN LANDINGHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-12-1487</u>	
17. INFORMANT & ADDRESS <u>Caroline E. Headley</u> <u>208 Annapolis Blvd</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 177X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Carcinomatosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Prostatic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 yr.</u> <u>5 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <u>Nov. 23, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Prostate</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/10/1950</u> to <u>2/16/1956</u> , that I last saw the deceased alive on <u>2/16/1956</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J.W. Prichard</u> M.D.		DATE SIGNED <u>2/16/56</u>	
ADDRESS (Street, city, town, state) <u>Glen Burnie, Md</u>		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	
DATE THEREOF <u>2/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Baltimore 25, AA Co., Md.</u>		24. RECEIVED BY REGISTRAR <u>Feb. 20, 1956</u>	
REGISTRAR'S SIGNATURE <u>James D. Kirkley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>	
ADDRESS <u>Glen Burnie, Md.</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL		16. SIGNATURE OF CREMATION	
17. SIGNATURE OF INTERMENT		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER	
23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
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49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER	
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63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER	
75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
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87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

NOTIFICATION

NOTIFICATION  
 The undersigned hereby certifies that the foregoing is a true and correct copy of the original record as the same appears in the files of the Department of Health of the State of Maryland.  
 WITNESSED my hand and the seal of the Department of Health of the State of Maryland at Baltimore, Maryland, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

RECEIVED  
 FEB 20 19\_\_\_\_

01302

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1350

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jessup, Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		STREET ADDRESS (If rural, give location) <u>406 Folsom St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH		(Month) (Day) (Year)
<u>Emma</u>		<u>S.</u>	<u>Herzog</u>		<u>2/25/56</u>		<u>19</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>3/17/70</u>	9. AGE last birthday <u>85</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Anna Snyder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>--</u>		17. INFORMANT AND ADDRESS <u>Mrs. Emma Zalud Jessup, Md.</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a) <u>Occlusion Coronary</u>		<u>1 hr</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Myocarditis - Endocarditis</u>		<u>None</u>
(c) <u>Secondary anemia</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24, 1956, to 7-25, 1956, that I last saw the deceased alive on 7-25, 1956, and that death occurred at 9:20 p.m., from the causes and on the date stated above.

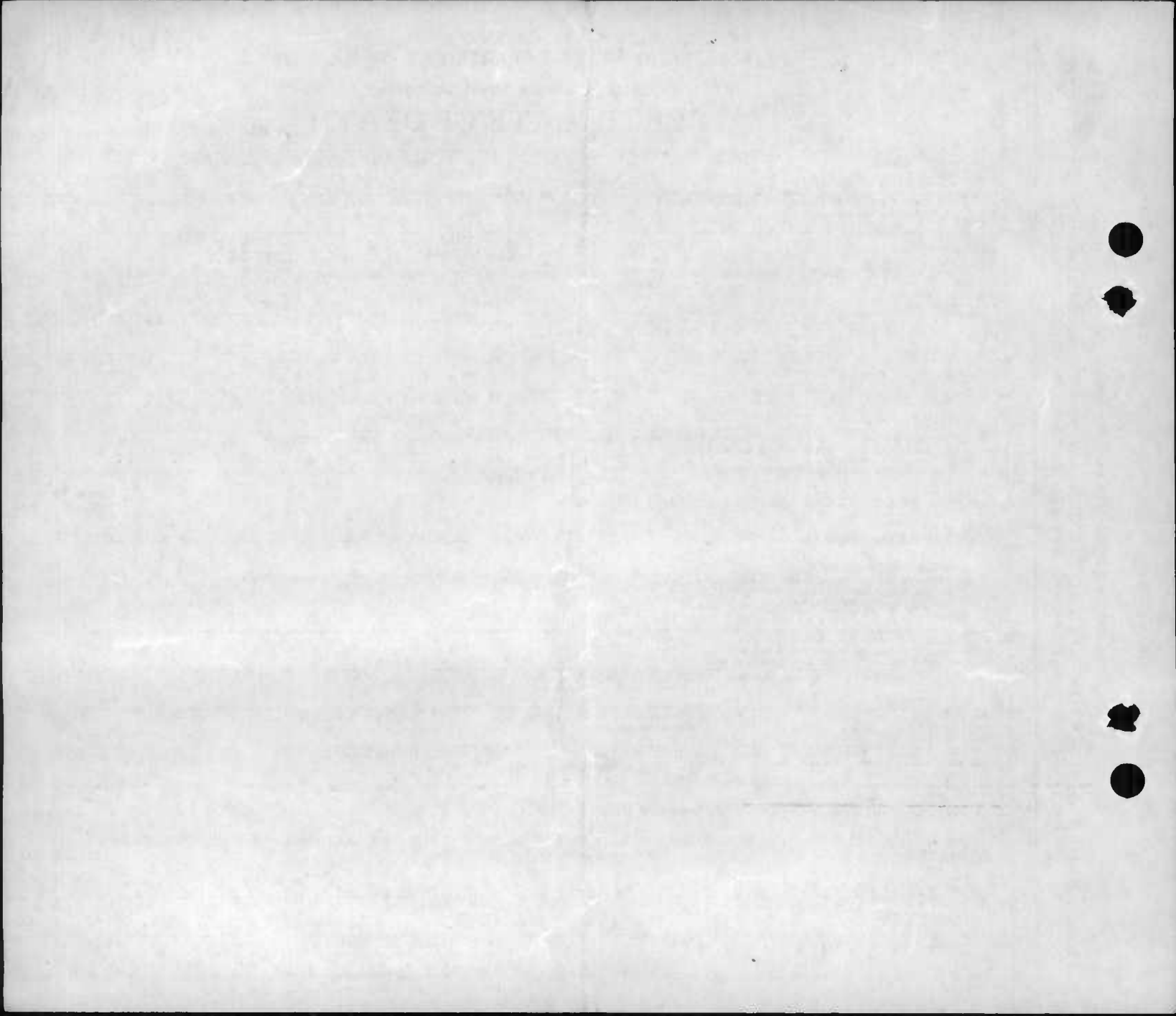
SIGNATURE W.B. Starnes MD (Degree or title) ADDRESS 314 Confinan Lane Md. DATE SIGNED 7-27/56

23. BURIAL CREMATION REMOVED (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/29/56</u>	<u>Baltimore Cem.</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	<u>W.B. Starnes</u>	<u>JOHN F. DENNY, INC.</u>	<u>715 Light St.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



correct age

1351 MARYLAND STATE DEPARTMENT OF HEALTH

01303

# Item 18 Film G193 3-13-56 ans CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

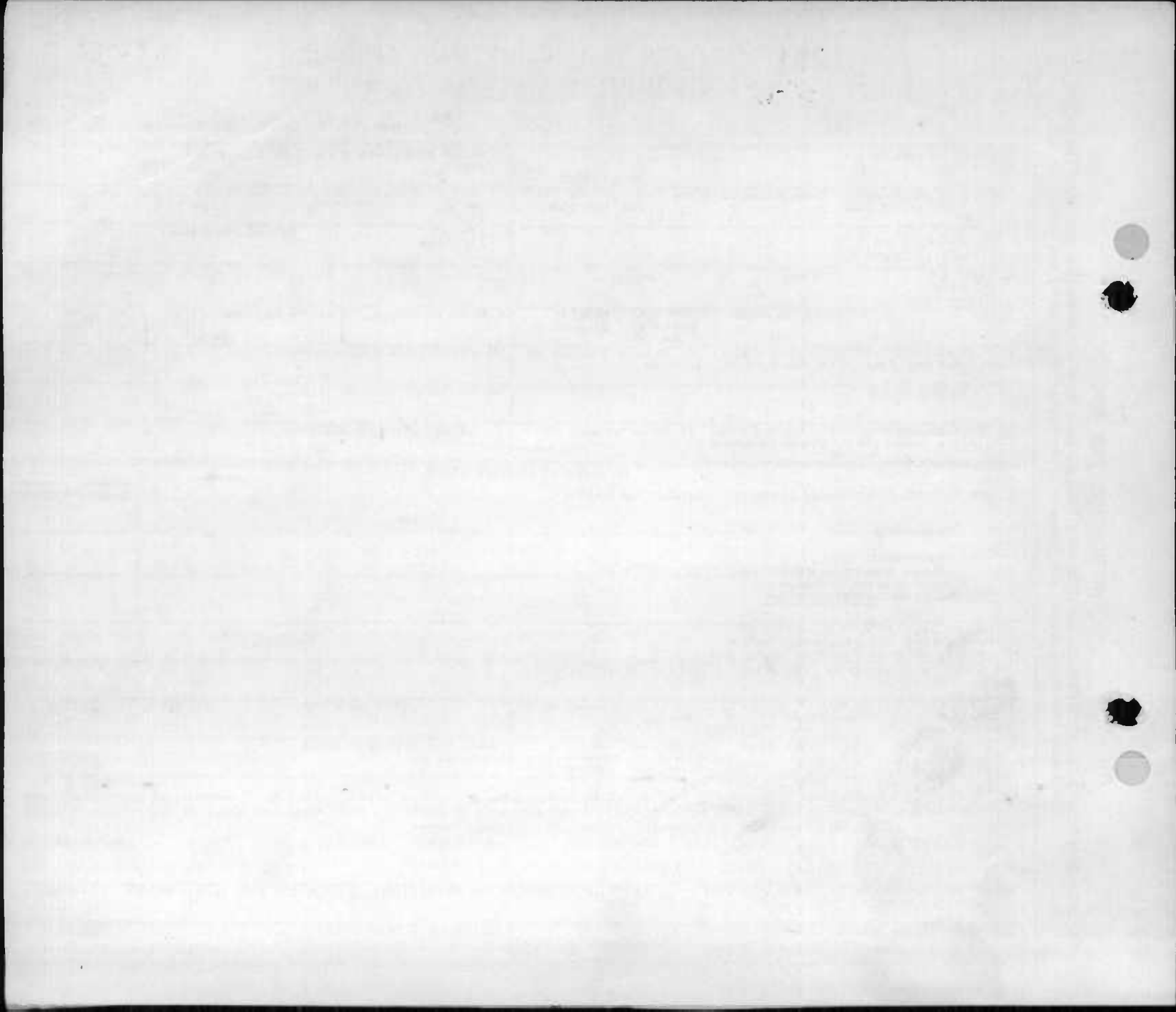
Reg. Dist. No. ....

1. NAME OF DECEASED (Type or Print) <b>EDGAR QUINTIN HOLLOWAY</b>			2. DATE OF DEATH <b>2-23-56</b>		
3. PLACE OF DEATH: <b>3 mi. N. of Odenton Station</b> A. <del>Baltimore City, Maryland</del> <b>on P.R.R.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Delaware</b> B. COUNTY <b>Wilmington</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Anne Arundel County</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>462</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>315 36th Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 16, 1896</b>		9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor Penna RR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>R R</b>	11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Franklin Holloway</b>			14. MOTHER'S MAIDEN NAME <b>Emily Riley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs Margaret C. Holloway</b>		ADDRESS <b>Wilmington Del</b>

18. <b>800X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>SKULL XX</b>		CAUSE OF DEATH <b>Skull Fracture</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Contusion of brain</b> DUE TO <b>Train derailed: 2-23-56 5:26 P.M.</b>		
		(C) <b>Injury occurred 3 miles north of Odenton Station P.R.R.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
23A. SIGNATURE <i>Wm. H. Smith</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR..... M.D.		23C. DATE SIGNED <b>2-21-56</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>Feb. 24, 1956</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Wilmington</b>	24D. LOCATION (City, town, or county) (State) <b>Del.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>2/24/56</b>	REGISTRAR'S SIGNATURE <i>A. H. Hedrick</i>	25. FUNERAL DIRECTOR <b>Albert J. McCrory</b>		ADDRESS <b>700 Washington St Wilmington Del.</b>

THIS IS A PERMANENT RECORD.  
PLEASE TYPE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of inform be carefully supplied. Physicians: please write the causes of death clearly and leg



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01304

## 1352 CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X <u>Fort G.G. Meade, Md.</u>		<u>1 1/2 yrs</u>		<u>Fort George G. Meade</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 U. S. Army Hospital</u>				<u>A Co, 69th Sig Bn</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ROBERT</u> (Middle) <u>M.</u> (Last) <u>HOLT</u>				(Month) <u>February</u> (Day) <u>20</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>May 1, 1914</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Soldier</u>		<u>U. S. Army</u>		<u>St. Marys County, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Philip Holt</u>				<u>Sarah Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>12 years</u>		<u>Violet Cooper</u> <u>309 W Street, N. W. Washington, D. C.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cardiac failure, acute left ventricular failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>DOA</u>			
ANTECEDENT CAUSE(S) DUE TO <u>etiology undetermined.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
✓							
22. I hereby certify that I attended the deceased from <u>20 Feb 56</u> to <u>20 Feb 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>20 Feb 56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>GENE D. TRETIN</u>		Ft CG Meade, Md.		ADDRESS (Street, city, town, state)		20 Feb 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>WILLIAM L. SAYLOR, IST LT, MSC</u>		<u>Phillips Funeral Home, Balto, Md</u>					
DATE <u>20 Feb 56</u>							



1313

01305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

## 1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN AnnapolisLENGTH OF STAY  
(In this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSDOA Anne Arundel General

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne ArundelCITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN AnnapolisSTREET ADDRESS  
(If rural, give location)  
703 Severn Ave.3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

CAROLYNCHUGHES

4. DATE

(Month) (Day) (Year)

OF

DEATH

FEBRUARY 1119 56

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Widowed

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleWhiteApril 23, 187778 yrs.10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):  
House wife10b. KIND OF BUSINESS OR  
INDUSTRY:  
Own Home11. BIRTHPLACE (State or foreign country):  
Winchester, A.A.Co.Md.12. CITIZEN OF WHAT  
COUNTRY?  
USA

## 13. FATHER'S NAME:

John Winchester

## 14. MOTHER'S MAIDEN NAME:

Laura Winchester15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY No.:

none

## 17. INFORMANT &amp; ADDRESS:

Mr John Hughes, Son same as # 2

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Cerebral Hemorrhage

Antecedent cause(s)

(b)

Diseases or conditions, if any,  
giving rise to the above cause DUE TO  
stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN  
ONSET AND DEATHSudden

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY:

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY Home

21c. (City or town)

(County)

(State)

AnnapolisAnne ArundelMaryland21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY Feb. 11, 1956 12:45 P.M.21e. INJURY OCCURRED  
While at Not while  
work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

Natural causes22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and  
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

Elmer G. Linhardt

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

☒ Feb. 11, 5623. BURIAL, CREMATION,  
REMOVAL (Specify):Burial

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

Feb. 14, 56St. Mary's CemeteryAnnapolis, MarylandDATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Feb. 14, 195610 - O. FrenchHopping Funeral HomeAnnapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

FEB 16 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1353  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 18422 File G193 3-13-56 ems  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

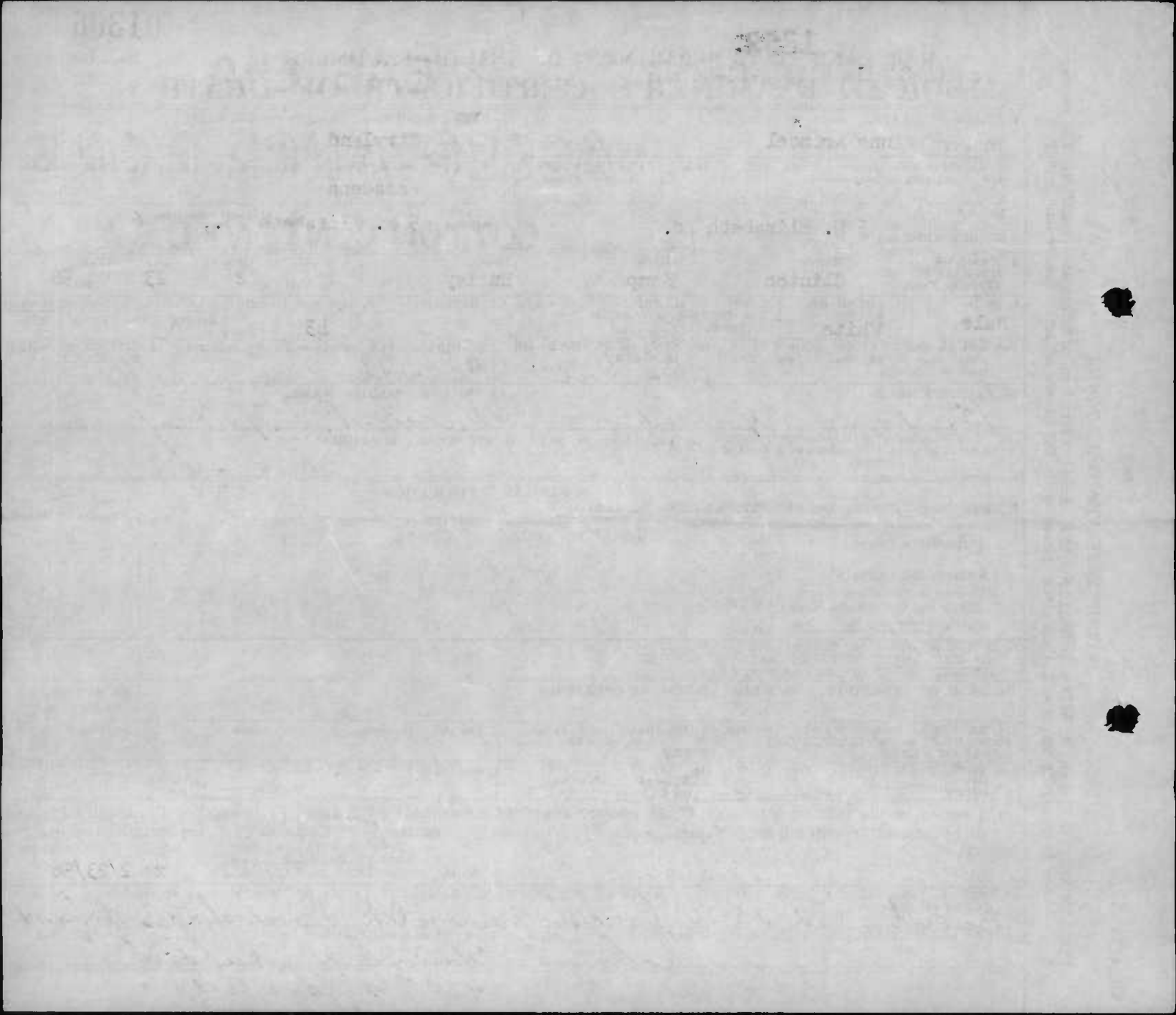
01306

Reg. Dist.

No. 21

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Pasadena</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 N. Elizabeth Rd.</u>				STREET ADDRESS <u>5 N. Elizabeth Rd., RFD 6</u> (If rural, give location)			
<b>3. NAME OF DECEASED:</b> (Type or Print)		(First) <u>Clinton</u>		(Middle) <u>Kemp</u>		(Last) <u>Hurley</u>	
				<b>4. DATE OF DEATH</b>		<b>5. AGE last birthday:</b>	
				(Month) <u>2</u> (Day) <u>23</u> (Year) <u>1956</u>			
<b>5. SEX:</b> <u>Male</u>	<b>6. COLOR OR RACE:</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Married</u>	<b>8. DATE OF BIRTH:</b> <u>Oct 2, 1912</u>	<b>9. AGE last birthday:</b> <u>43</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Truck Driver</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Oldtown, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Yes</u>	
<b>13. FATHER'S NAME:</b> <u>Baynard Hurley</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Martha R. Hurley</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>  </u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY No.:</b> <u>  </u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>  </u>			

<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>					
<u>976x</u> <b>Immediate cause</b> (a) <u>Gunshot wound of Chest</u> DUE TO <b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) <u>  </u>					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>			
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></b>		<b>21b. PLACE</b> (Home, farm, factory, OF street, office bldg., etc., INJURY)		<b>21c. (City or town) (County) (State)</b>	
<b>21d. TIME</b> (Month) (Day) (Year) (Hour) OF INJURY		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
<b>SIGNATURE</b> <u>Earl F. Green</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>M. D. ASSISTANT MEDICAL EXAM.</b> <input checked="" type="checkbox"/> <u>2/23/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>		<b>DATE THEREOF</b>			
<u>Burial</u>		<u>2-25-56</u>			
<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>			
<u>Dorchester Memorial Park</u>		<u>Dorchester, Cambridge, Md</u>			
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR ADDRESS</b>	
<u>Feb 23, 1956</u>		<u>A. W. Healdreich</u>		<u>Howard J. Hubbard</u> <u>4107 Wilbers Ave</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1354				01307			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 21			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Thomas Boatyard</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Fourth Street</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>CHARLES</u>		<u>MARTIN</u>		<u>INMAN</u>		<u>2</u> <u>9</u> <u>19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>S</u>	<u>June 10, 1940</u>	<u>15</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Student</u>		<u>2nd High School</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert F. Inman Sr.</u>				<u>Marie A. Lowman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
- - - - -		- - - - -		<u>Mr Robert F. Inman Sr. Father same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Drowning</u> DUE TO Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Boatyard</u>		21c. (City or town) (County) (State)			
<u>Annapolis</u> <u>Anne Arundel</u> <u>Maryland</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>?</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>While riding bike</u> <u>Accidentally drowned self.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William J. [Signature]</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/9/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 11, 56</u>		<u>Hillcrest Cemetery</u>		<u>Annapolis, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-11-56</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD.</u>	

BUREAU V. S.

FEB 16 1956

RECEIVED

1355 CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>A.A. Co.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>A.A. Co.</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Harmons</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Harmons</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 Dorsey Rd.</b>		STREET ADDRESS (If rural give location) <b>Dorsey Rd. Box 115 B.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>PINKEY JACKSON</b>		DATE OF DEATH: <b>FEB. 12, 1956</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH: <b>Jan. 25, 1860</b>
		9. AGE last birthday <b>95</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Nelson Co. Va.</b>
13. FATHER'S NAME: <b>James Brown</b>		14. MOTHER'S MAIDEN NAME: <b>Martha ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Bessie Mundell Box 115 B.</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Pneumonia</b>			
ANTECEDENT CAUSE (S) <b>Senile Dementia</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 13, 1956</b> to <b>Feb. 12, 1956</b> , that I last saw the deceased alive on <b>2-12-1956</b> and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>[Signature]</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 16, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Proffits Va.</b>		LOCATION (City, town, or county) (State) <b>Proffits Va.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2-15-56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>322</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
BUREAU OF COMMUNITY HEALTH

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correct age

THIS IS A PERMANENT RECORD.  
PLEASE TYPE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of informal be carefully supplied. Physicians: please write the causes of death clearly and leg

0046

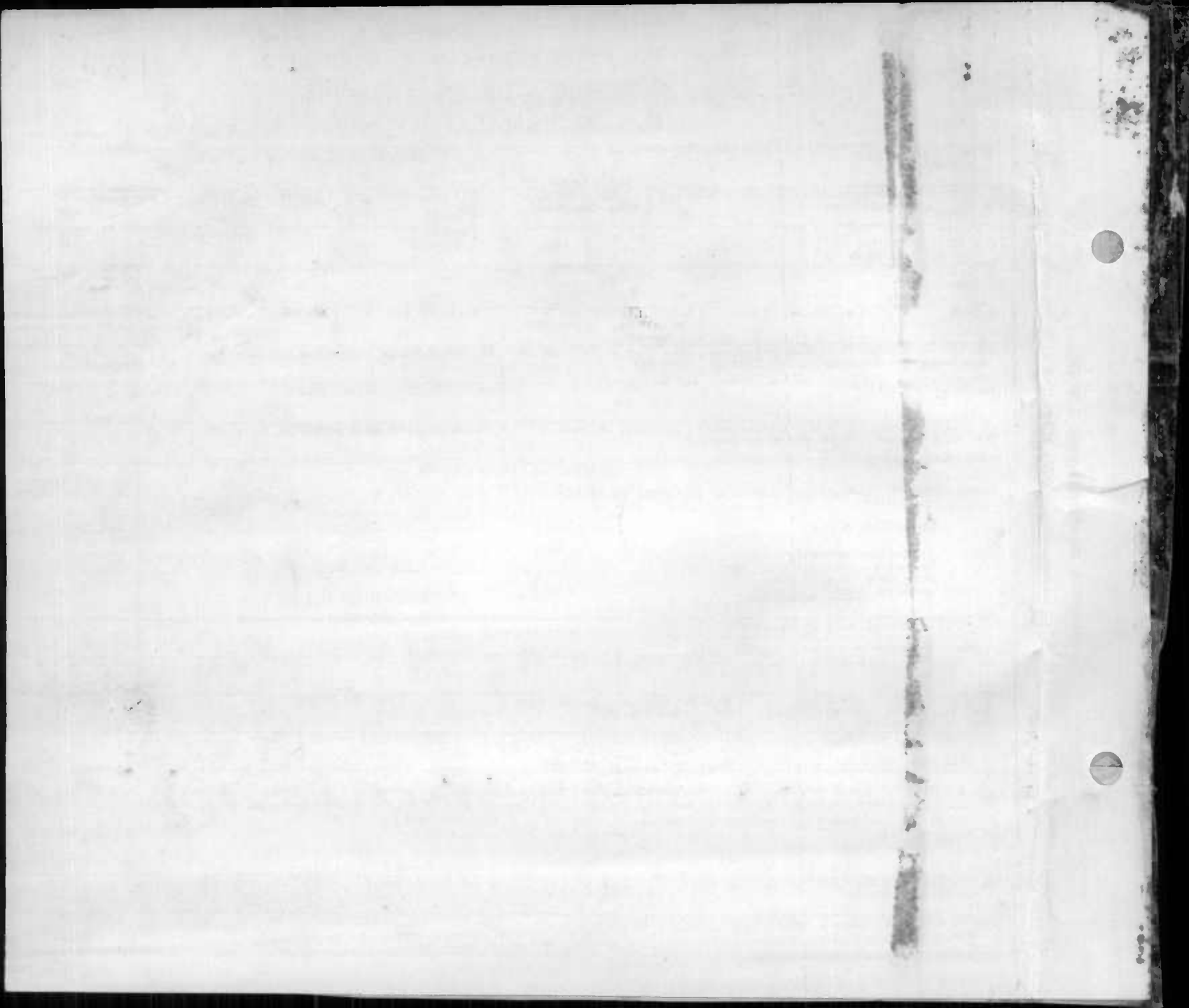
MARYLAND STATE DEPARTMENT OF HEALTH

01309

Item 18 Film G193 3-13-56 am **CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>SIDNEY JACKSON</b>			2. DATE OF DEATH <b>2-23-56</b>		
3. PLACE OF DEATH: <b>3 Mi. N. of Odenton Station</b> A. <b>Baltimore City, Maryland on P.R.R.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>New York City, N.Y.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Anne Arundel County</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>New York City,</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>133 W. 116th Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH	9. AGE (in years last birthday) <b>50</b>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Jackson</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <b>800X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Extensive crushing injury of chest with massive bilateral hemothorax.</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Train derailed: 2-23-56 5:26 P.M.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Injury occurred 3 miles north of Odenton Sta. on P.R.R.</b>					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Partial</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
23A. SIGNATURE <i>William Upchurch</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>2-24-56</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>3-1-56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Holiness Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Butler, New Jersey.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <i>25-1-56 R.W.</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>		25. FUNERAL DIRECTOR <i>Mrs. Frances A. Fennell</i> ADDRESS <b>578W Biddle St.</b>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1356 CERTIFICATE OF DEATH

01310

Reg. Dist. No. 25

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>D.A.</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>D.A.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Brooklyn</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		TOWN <i>50</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>#1, 6th Ave</i>				STREET ADDRESS (If rural give location) <i>#1, 6th Ave</i>			
<b>3. NAME OF DECEASED</b> (First) <i>Louis</i> (Middle) <i>C.</i> (Last) <i>Sagee</i>				<b>4. DATE OF DEATH</b> (Month) <i>2</i> (Day) <i>20</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>M.</i>	<b>6. COLOR OR RACE</b> <i>W.</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>W.</i>	<b>8. DATE OF BIRTH</b> <i>10/2/74</i>	<b>9. AGE last birthday</b> <i>81</i> yrs.	<b>IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i>		<b>IF UNDER 24 HRS.</b> Hours <i>0</i> Min. <i>0</i>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>MD. MARGEE (Nurse)</i>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>MD.</i>	<b>11. BIRTHPLACE</b> (State or foreign country) <i>MD.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>Louis</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>MARGARET Steinfeld</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT &amp; ADDRESS</b> <i>Family - Same</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>144X IMMEDIATE CAUSE (A)</b> <i>Cancer of the buccal cavity</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>9 mo.</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>FEB 7, 1956</i> , to <i>FEB 20, 1956</i> , that I last saw the deceased alive on <i>FEB 20, 1956</i> , and that death occurred at <i>6:35 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>V. J. Ginnald</i>				<b>DATE SIGNED</b> <i>2-22-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <i>5/24/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Holy Cross</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Bethesda</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Ada Whitson</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. L. Lacey</i>		<b>ADDRESS</b> <i>St. Anne's Home</i>	
<b>DATE</b> <i>FEB 24 1956</i>							

BUREAU V.S.

FEB

RECEIVED

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1357 CERTIFICATE OF DEATH

01311

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Calvert</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Crownsville</b>	LENGTH OF STAY (in this place) <b>3yrs.8mos.20days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Island Creek</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Crownsville State Hospital</b>		STREET ADDRESS (If rural give location) <b>None listed</b>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Maggie Jefferson</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>2 16 19 56</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Not given</b>
<b>9. AGE last birthday</b> <b>81?</b> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.) <b>— — — —</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None given</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>— — — —</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>	
<b>13. FATHER'S NAME</b> <b>Not given</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Not given</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Records</b>	
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>002X</b> IMMEDIATE CAUSE (A) <b>Respiratory Failure</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Pulmonary Tuberculosis</b>			<b>2 years</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b> <b>2</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 5/27, 1952, to 2/16, 1956, that I last saw the deceased alive on 2/16, 1956, and that death occurred at 5:30p.m. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>L. Benedict</i>		<b>ADDRESS (Street, city, town, state)</b> <b>Crownsville, Md.</b>	
<b>DATE SIGNED</b> <b>2/17/56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>	
<b>24. NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>25. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>	
<b>26. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b>			

# 1957 CERTIFICATE OF DEATH

W-2 (Rev. 10-1-56)

1. NAME OF DECEASED

John A. Smith

2. SEX

Male

3. RACE

White

4. DATE OF BIRTH

10-1-1900

5. PLACE OF BIRTH

MD

6. DATE OF DEATH

10-1-1957

7. TIME OF DEATH

10:00 AM

8. PLACE OF DEATH

Home

9. CAUSE OF DEATH

Heart Disease

10. MEDICAL HISTORY

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF DECEASED

BUREAU V. S.

FEB 21 1958

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01312

## 1314 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A.Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BAY RIDGE RD.</u>				STREET ADDRESS (If rural give location) <u>BAY RIDGE RD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ralph</u> (Middle) <u>Roy</u> (Last) <u>Johnson</u>				(Month) <u>2</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8/24/1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASTER AT ARMS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Sophia A. M. Johnson #2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>						<u>8 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>55</u> , to <u>2/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>56</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward S Beck</u>				DATE SIGNED <u>2/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>2/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		LOCATION (City, town, or county) <u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. J. O'Connell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		ADDRESS <u>Annapolis Md.</u>	
DATE <u>Feb. 14, 1956</u>							

# 1. CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DEATH OF

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

BUREAU V. S.

FEB 16 1956

RECEIVED

DEATH OF

DEATH OF

1358

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801313

Item 18 Film G193 3-13-56

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. NAME OF DECEASED (Type or Print) <b>THOMAS REED JOHNSON</b>			2. DATE OF DEATH <b>2-23-56</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland on P.R.R.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Anne Arundel County</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6, 03X-2</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>1816 Ellinwood Road</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 28, 1921</b>		9. AGE (In years last birthday) <b>34</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Project Mgr.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Glenn L. Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Waverly, Va.</b>
13. FATHER'S NAME <b>Wesley Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Reed</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W. 2</b>			16. SOCIAL SECURITY NO. <b>229-03-9716</b>		17. INFORMANT <b>Mrs. Thos. R. Johnson, 1816 Ellinwood Rd.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			ADDRESS <b>Balto. Md</b>		

18. <b>801X</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Fracture of the pelvis</b>		
ANTECEDENT CAUSES		(B) <b>Laceration of the buttocks with evisceration of abdominal contents</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>Train derailed: 2-23-56 5:26 P.M.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Injury occurred 3 miles north of Odenton Sta. on P.R.R.</b>		

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2-23-56</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Train derailed</b>		
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
23A. SIGNATURE <i>William Updegraff</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>2-24-56</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>2/27/56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>FEB 28 1956</b>	REGISTRAR'S SIGNATURE <i>Charles H. Taylor</i>	25. FUNERAL DIRECTOR <i>Charles H. Taylor</i>		ADDRESS <b>7401 Belair Rd.</b>

The  
 THIS IS A PERMANENT RECORD.  
 PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
 Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg

RECEIVED

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 1359 CERTIFICATE OF DEATH

01314

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>3mos. 27 days</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Frederick</u>		TOWN <u>10-11-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>		STREET ADDRESS (If rural give location) <u>302 Middle Alley</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Katie</u> <u>Jones</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2</u> <u>1</u> <u>19 56</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>9/5/81</u>	
<b>9. AGE last birthday</b> <u>74</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> — — — —		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>	
<b>13. FATHER'S NAME</b> <u>Stephen Brown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Elliott</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>029X</u> IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Syphilis</u>							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> — — — —		<b>19b. MAJOR FINDINGS OF OPERATION</b> — — — —				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> — — — —		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) — — — —			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) — — — — M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> — — — —			
<b>22. I hereby certify that I attended the deceased from</b> <u>10/5</u> , 19 <u>55</u> , to <u>2/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>56</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>L. Benedict, M. D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Crownsville, Md.</u>		<b>DATE SIGNED</b> <u>2/1/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>2-7-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Middle Frederick</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Frederick Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>2/4/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>W. M. Joyce</u>		<b>FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Hicks</u>		<b>ADDRESS</b> <u>1414 W. Saint Frederick</u>	

# CERTIFICATE OF DEATH

Form 100-1-55

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. AGE

13. OCCUPATION

14. CAUSE OF DEATH

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. SEX

19. AGE

20. OCCUPATION

21. CAUSE OF DEATH

22. DATE OF DEATH

23. TIME OF DEATH

24. SEX

25. AGE

26. OCCUPATION

27. CAUSE OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

30. SEX

31. AGE

32. OCCUPATION

33. CAUSE OF DEATH

34. DATE OF DEATH

35. TIME OF DEATH

36. SEX

37. AGE

38. OCCUPATION

39. CAUSE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. SEX

43. AGE

44. OCCUPATION

45. CAUSE OF DEATH

46. DATE OF DEATH

47. TIME OF DEATH

48. SEX

49. AGE

50. OCCUPATION

51. CAUSE OF DEATH

52. DATE OF DEATH

53. TIME OF DEATH

54. SEX

55. AGE

56. OCCUPATION

57. CAUSE OF DEATH

58. DATE OF DEATH

59. TIME OF DEATH

BUREAU V. S.

FEB 9 1956

RECEIVED

200172124

BALTIMORE

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01315

## 1360 CERTIFICATE OF DEATH

Item 9, Film G192 2-9-56 et

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		STATE <u>Illinois</u>		COUNTY <u>Cook</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft GG Meade</u>		<u>1 hour</u>		TOWN <u>LaGrange</u>		<u>51X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>201 South Edgewood</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>CHARLES E. KINSEY</u>				<u>February 1 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>31 October 1932</u>	<u>23</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Soldier</u>			<u>US Army</u>		<u>Washington</u>		<u>USA</u>
13. FATHER'S NAME <u>Maurice Everett Kinsey</u>				14. MOTHER'S MAIDEN NAME <u>Francis Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes since Sept 55</u>				<u>533-28-7350</u>		<u>Army Service records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Shock</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Nasopharyngeal hemorrhage, cerebral injury</u>				<u>1 hour</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Nasopharyngeal hemorrhage, cerebral injury</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>street</u>		<u>Route 301, Anne Arundel, Maryland</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>02 1500 Feb 1 56 M.</u>		<u>1 Feb 56</u>		<u>Bus accident</u>			
22. I hereby certify that I attended the deceased from <u>Jan 19 56</u> to <u>Jan 19 56</u> , that I last saw the deceased alive on <u>1 Feb 56</u> , and that death occurred at <u>3:55 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>CHARLES KARPINSKI</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Charles Karpinski</u>				<u>Fort GG Meade, Maryland</u>		<u>1 Feb 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-3-56</u>		<u>LaGrange, Illinois</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2 Feb 56</u>		<u>WILLIAM L. Saylor, 1/Lt, MSC</u>		<u>WM. COOK, INC., PALTO., MD</u>			

# MARIANO STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH

## CERTIFICATE OF DEATH

1. NAME - SURVIVOR FROM THE DECEASED

2. NAME - SURVIVOR FROM THE DECEASED

3. NAME - SURVIVOR FROM THE DECEASED

4. NAME - SURVIVOR FROM THE DECEASED

5. NAME - SURVIVOR FROM THE DECEASED

6. NAME - SURVIVOR FROM THE DECEASED

7. NAME - SURVIVOR FROM THE DECEASED

8. NAME - SURVIVOR FROM THE DECEASED

9. NAME - SURVIVOR FROM THE DECEASED

**BUREAU V. S.**

FEB 6 1956

**RECEIVED**

1315

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis 10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>63 St. General</i>		d. STREET ADDRESS <i>11 McKendree Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>THOMAS</i> Middle <i>H.</i> Last <i>KIRBY</i>		4. DATE OF DEATH Month <i>2</i> Day <i>28</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-22-1891</i>
9. AGE (In years lost birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>4</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Academy</i>	
11. BIRTHPLACE (State or foreign country) <i>aa Co Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Floyd S. Kirby</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Lee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes WWI</i>		16. SOCIAL SECURITY NO. <i>Lucy C. Kirby</i>	
17. INFORMANT <i>Lucy C. Kirby</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>with Congestive Failure</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i> <i>UNKNOWN</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/20</i> , 19 <i>56</i> , to <i>2/28</i> , 19 <i>56</i> that I last saw the deceased alive on <i>2/28</i> , 19 <i>56</i> , and that death occurred at <i>11:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward S. Beck</i>		ADDRESS (Street, city or town, state) <i>41 Southgate Ave</i> DATE SIGNED <i>2/29/56</i>	
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>		<i>ANNAPOLIS, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-2-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>March 1 '56</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. Daniel</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

## 1316 CERTIFICATE OF DEATH

Item 14, Film G193 2-24-56 et

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>D.C.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. TOWN <i>Baltimore</i>				TOWN <i>Churchton</i>			
13. HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Dane Arnold General</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>George H. Kirchner</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 10, 1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>		8. DATE OF BIRTH <i>Jan. 29, 1886</i>	
				9. AGE last birthday <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <i>Marine Railway</i>		11. BIRTHPLACE (State or foreign country) <i>Churchton, Md.</i>	
13. FATHER'S NAME <i>George H. Kirchner</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Joyce</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. <i>331X</i>		17. INFORMANT & ADDRESS <i>George Kirchner Jr. Churchton, Md.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/7/56</i> , to <i>2/10/56</i> , that I last saw the deceased alive on <i>2/9/56</i> , and that death occurred at <i>4:17</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Frank M. Shipley</i>				ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>			
DATE <i>2/13/56</i>				DATE SIGNED <i>2/12/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/13/56</i>		NAME OF CEMETERY OR CREMATORY <i>Woodfield</i>		LOCATION (City, town, or county) (State) <i>Galesville, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Benjamin H. Gandy</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin H. Gandy</i>			
DATE <i>2/13/56</i>		ADDRESS <i>Thos. J. French</i>					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

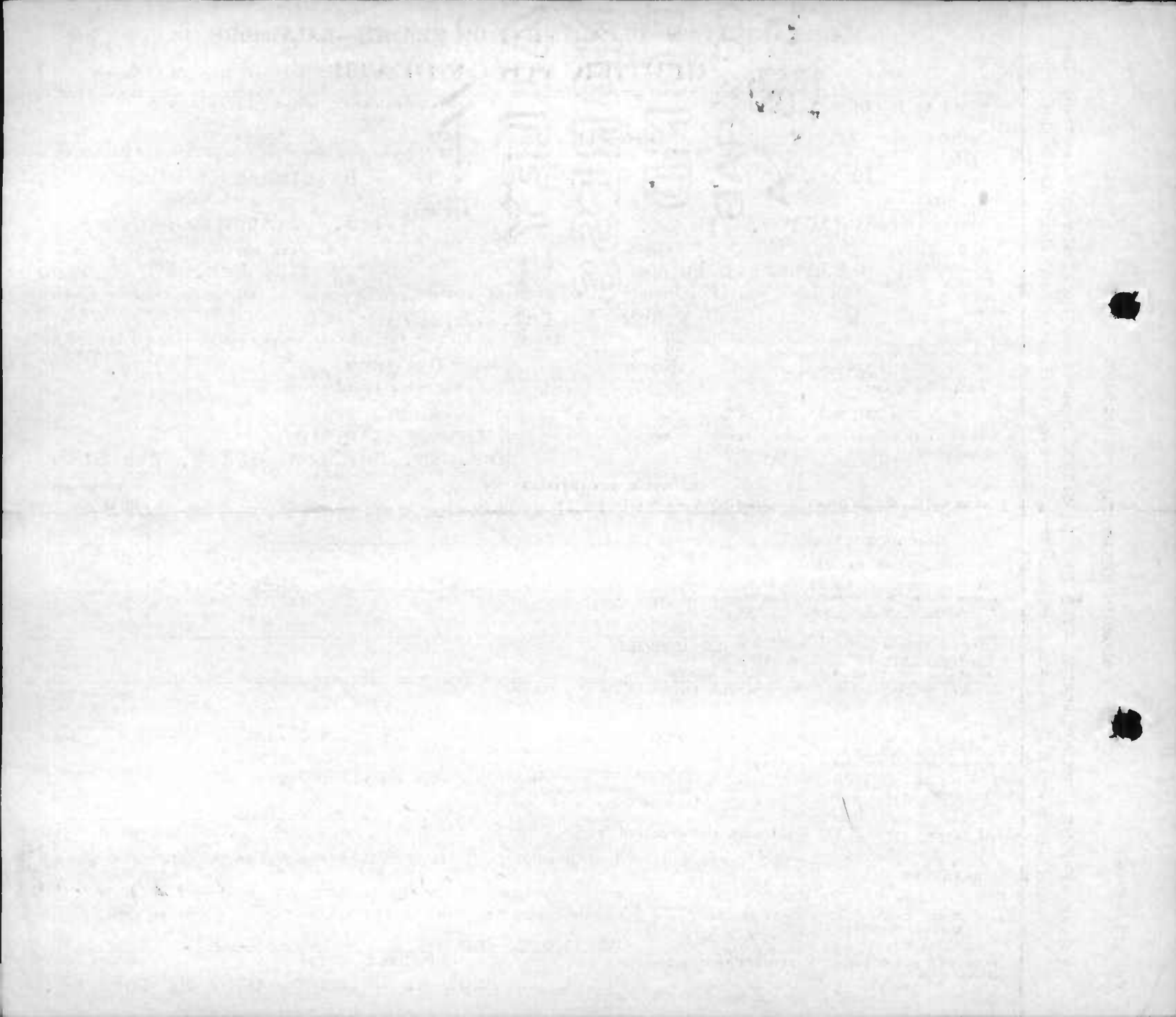
RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **01318**  
 Items 1, 12 Film 191 3-16-56 et  
**1361** CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> TOWN <u>Brooklyn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>101 W. 7th St.</u>		STATE <u>Md</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) _____ OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>411 S. Clinton St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elizebeth Kunze</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 25, 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Oct. 28, 1875</u>
9. AGE last birthday: <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Germany</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Conrad Kraft</u>		14. MOTHER'S MAIDEN NAME: <u>Anna ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <u>Mrs. Wm. Gallion 101 W. 7th St</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Coronary Thrombosis</u>		<u>10 min</u>	
ANTECEDENT CAUSE (S): (B) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Nov 12, 1955</u> to <u>25 Feb, 1956</u> , that I last saw the deceased alive on <u>25 Feb, 1956</u> , and that death occurred at <u>11:45</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Raymond Budann</u>		ADDRESS <u>5010 Litchie Hwy</u> DATE SIGNED <u>27 Feb 56</u>	
M. D. _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/28/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>27-56</u>		REGISTRAR'S SIGNATURE <u>(Signature)</u>	
24. FUNERAL DIRECTOR <u>Paul A. Heemann</u>		ADDRESS <u>6067 Harford Rd.</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1362 CERTIFICATE OF DEATH

01319

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>A.A</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Crownsville</i>		LENGTH OF STAY (in this place) <i>25 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>10 Crownsville State Hospital</i>				STREET ADDRESS (If rural give location) <i>21 Washington Street</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>John</i> (First) <i>Larkins</i> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Feb. 24 1956</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>single</i>	<b>8. DATE OF BIRTH</b> <i>Unknown</i>		<b>9. AGE last birthday</b> <i>73</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>—</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A</i>	
<b>13. FATHER'S NAME</b> <i>Dennis Larkins</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Caroline Snowden</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>NO</i>		<b>16. SOCIAL SECURITY NO.</b> <i>unknown</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Hospital Records</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <i>450.0 Generalized and Cerebral Arteriosclerosis</i>						<i>years</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Senility</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Mental Deficiency</i>							
<b>19a. DATE OF OPERATION</b> <i>none</i>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>—</i>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>2-24</i>, 19<i>56</i>, to <i>2-24</i>, 19<i>56</i>, that I last saw the deceased alive on <i>2-24</i>, 19<i>56</i>, and that death occurred at <i>5:00 P.</i>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Stanley C. Searcy</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Crownsville, Md.</i>		<b>DATE SIGNED</b> <i>2-25-56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Buried</i>		<b>DATE THEREOF</b> <i>3/4/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Brewer Hill</i>		<b>LOCATION (City, town, or county)</b> <i>Annapolis</i> (State)	
<b>24. RECD BY REGISTRAR</b> <i>155</i>		<b>REGISTRAR'S SIGNATURE</b> <i>H. M. Joyce</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>J. P. Johnson</i>		<b>ADDRESS</b> <i>Annapolis</i>	

DATE

# CERTIFICATE OF DEATH

FILE NO. 10

DATE OF DEATH

DECEASED

PLACE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

AGE

EDUCATION

HEIGHT

WEIGHT

HAIR

EYES

SKIN

TEETH

NOSE

THROAT

NECK

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

SEMINAL VESICLE

EPIDIDYMIS

SCROTUM

PENIS

CLITORIS

LABIA

VULVA

PERINEUM

ANUS

RECTAL

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

SEMINAL VESICLE

EPIDIDYMIS

SCROTUM

PENIS

CLITORIS

LABIA

VULVA

PERINEUM

ANUS

RECTAL

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

BUREAU V. 2

MAR 5 1956

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SHORTCUTS

THIS IS A SUMMARY OF THE INFORMATION CONTAINED IN THE ORIGINAL RECORD. IT IS NOT A SUBSTITUTE FOR THE ORIGINAL RECORD. IT IS NOT TO BE USED FOR LEGAL PURPOSES. IT IS NOT TO BE USED FOR MEDICAL PURPOSES. IT IS NOT TO BE USED FOR RESEARCH PURPOSES. IT IS NOT TO BE USED FOR STATISTICAL PURPOSES. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

1317

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>A.A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Amapolis</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1972 West. St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wallace</u> First Middle <u>Larkins</u> Last		4. DATE OF DEATH <u>Feb. 21</u> Month Day Year 19 <u>56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Ind. A.A. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Ind. A.A. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis Larkins</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Snowden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Henry Larkins</u>	
17. INFORMANT <u>Henry Larkins</u> Address <u>Amapolis, Ind.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree Burns - Entire body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House Caught on fire.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>2/21/56</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>West Street</u>		20f. (City or town) <u>Amapolis</u> (County) <u>AACO</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>19</u> to <u>2/21/56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		DATE SIGNED <u>2/21/56</u>	
PHYSICIAN'S NAME (Type) <u>F. L. Linhardt</u>		ADDRESS (Street, city or town, state) <u>Amapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 24/56</u>		22b. DATE THEREOF <u>Feb. 24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) <u>Amapolis</u> (State) <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annie A. Johnson</u> ADDRESS <u>Amapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>2/24/1956</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>		24c. REGISTRAR'S SIGNATURE <u>J. J. ...</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>21. SIGNATURE OF COUNTY CLERK</p>		<p>22. SIGNATURE OF STATE CLERK</p>		<p>23. SIGNATURE OF U.S. MARSHAL</p>		<p>24. SIGNATURE OF U.S. ATTORNEY</p>	
<p>25. SIGNATURE OF U.S. SENATOR</p>		<p>26. SIGNATURE OF U.S. REPRESENTATIVE</p>		<p>27. SIGNATURE OF GOVERNOR</p>		<p>28. SIGNATURE OF PRESIDENT</p>	

BUREAU V. 1

FEB 27 1956

RECEIVED

1318

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jewell</b>				d. STREET ADDRESS <b>RFD Dunkirk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>63 Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTOPHER COLUMBUS LEITCH</b>				4. DATE OF DEATH Month Day Year <b>February 25 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1881</b>		9. AGE (In years lost birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christopher C. Leitch</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Wach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>— — — — —</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Mrs Lois Leitch - same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Hyperlipemic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis generalized</b> DUE TO <b>49K5.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 23</b> , 19 <b>56</b> , to <b>Feb. 25</b> , 19 <b>56</b> that I last saw the deceased alive on <b>2/25</b> , 19 <b>56</b> , and that death occurred at <b>A</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Elmer G. Linhardt</b> M.D. <b>Annapolis Maryland</b> PHYSICIAN'S NAME (Type) <b>Dr. Elmer G. Linhardt</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Friendship, Anne Arundel, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. Hutchins</b>				ADDRESS <b>Owings, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>2-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>U. T. ...</b>			

# CERTIFICATE OF DEATH

1918

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 10-21

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
OCCUPATION		EDUCATION	
MARRIAGE		RELIGION	
BIRTH		DEATH	
FATHER		MOTHER	
SIBLINGS		OTHER RELATIVES	
PREVIOUS ILLNESS		TREATMENT	
BURIAL		INTERVIEW	
SIGNATURE OF REGISTRAR		DATE	

BUREAU V. S.

FEB 28 1956

RECEIVED

## 1363 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Virginia</i>	COUNTY <i>Lee</i>
CITY (If outside corporate limits, write OR and give nearest town) <i>Blair Burnie</i>	RURAL LENGTH OF STAY (in this place) <i>12 yrs</i>	CITY (If outside corporate limits, write OR and give nearest town) <i>Rose Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>box 426A-RT2 Blair Burnie, Md.</i>		STREET ADDRESS (If rural give location) <i>no street address</i>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>MARY</i>	(Middle) <i>SUE</i>	(Last) <i>LOVEYS</i>	(Month) <i>Feb</i> (Day) <i>14</i> (Year) <i>1956</i>
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid</i>	8. DATE OF BIRTH: <i>2 May 1881</i>
9. AGE last birthday: <i>74</i> yrs.		10. CITIZENSHIP: <i>yes</i>	
11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes</i>	
13. FATHER'S NAME: <i>Thomas Rosenbalm</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah Scott</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Son - James Loveys - same address</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <i>Cerebral Vascular accident</i>		<i>30 yrs</i>
Immediate cause DUE TO		
(b) <i>Hypertension</i>		<i>1 yr</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c) <i>Arteriosclerosis</i>		<i>10 yrs</i>

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION: <i>Sept 1954</i>		19b. MAJOR FINDINGS OF OPERATION: <i>Cataract removals</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>no</i>		20. PLACE (Home, farm, factory, street, office bldg., etc.) <i>no</i>	
TIME (Month) (Day) (Year) (Hour) <i>no</i>		HOW DID INJURY OCCUR ? <i>no</i>	

22. I hereby certify that I attended the deceased from <i>13 Feb</i> , 1956, to <i>14 Feb</i> , 1956, that I last saw the deceased alive on <i>13 Feb</i> , 1956, and that death occurred at <i>8:45 AM</i> from the causes and on the date stated above.			
SIGNATURE <i>H.F. Monizak M.D.</i>		DATE SIGNED <i>13 Feb 1956</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24. FUNERAL DIRECTOR <i>no</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb 15, 1956</i>		REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>	
REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>		ADDRESS <i>Blair Burnie, Md.</i>	

Patient previously treated by Dr. J. Lipsky of Blair Burnie.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1956

BUREAU V. S.

## 1319 CERTIFICATE OF DEATH

01323

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place) <u>1</u> Hour		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pasadena, Md.</u> <u>x</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66</u> <u>A.A. General Hospital</u>				STREET ADDRESS <u>RFD 5</u> (If rural give location) <u>Box 491 /</u> <u>Pake Shore, Pasadena, Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>F. Belle</u> (First) <u>Margaret</u> (Middle) <u>MARK</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb.</u> <u>29</u> <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 14, 1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 Year Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Will</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>RFD 5 Box 491</u> <u>George H. Mark Pasadena, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
260x IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>				<u>4 years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Jan. 20, 19 52</u>, to <u>Feb. 29, 19 56</u>, that I last saw the deceased alive on <u>Feb. 29, 19 56</u>, and that death occurred at <u>10:10 A.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>R. M. McLaughlin</u>		M.D. <u>RFD 8 Box 448 Pasadena, Md</u>		DATE SIGNED <u>Feb. 29, 19 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 6 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Lench</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Lench</u>		ADDRESS <u>4001 Ritchie Hwy</u>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# 1913 CERTIFICATE OF DEATH

File No. 100

1. USUAL RESIDENCE (Place of Birth)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH  
 6. DATE OF DEATH  
 7. TIME OF DEATH  
 8. PLACE OF DEATH

9. CAUSE OF DEATH

10. SEX

11. USUAL RESIDENCE (Place of Birth)

12. SEX

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. SEX

21. AGE

22. DATE OF BIRTH

23. PLACE OF BIRTH

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. CAUSE OF DEATH

28. SEX

29. AGE

30. DATE OF BIRTH

31. PLACE OF BIRTH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF DEATH

35. CAUSE OF DEATH

36. SEX

37. AGE

38. DATE OF BIRTH

39. PLACE OF BIRTH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. CAUSE OF DEATH

44. SEX

45. AGE

46. DATE OF BIRTH

47. PLACE OF BIRTH

BUREAU V. S.

MAR 7 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01324

1364

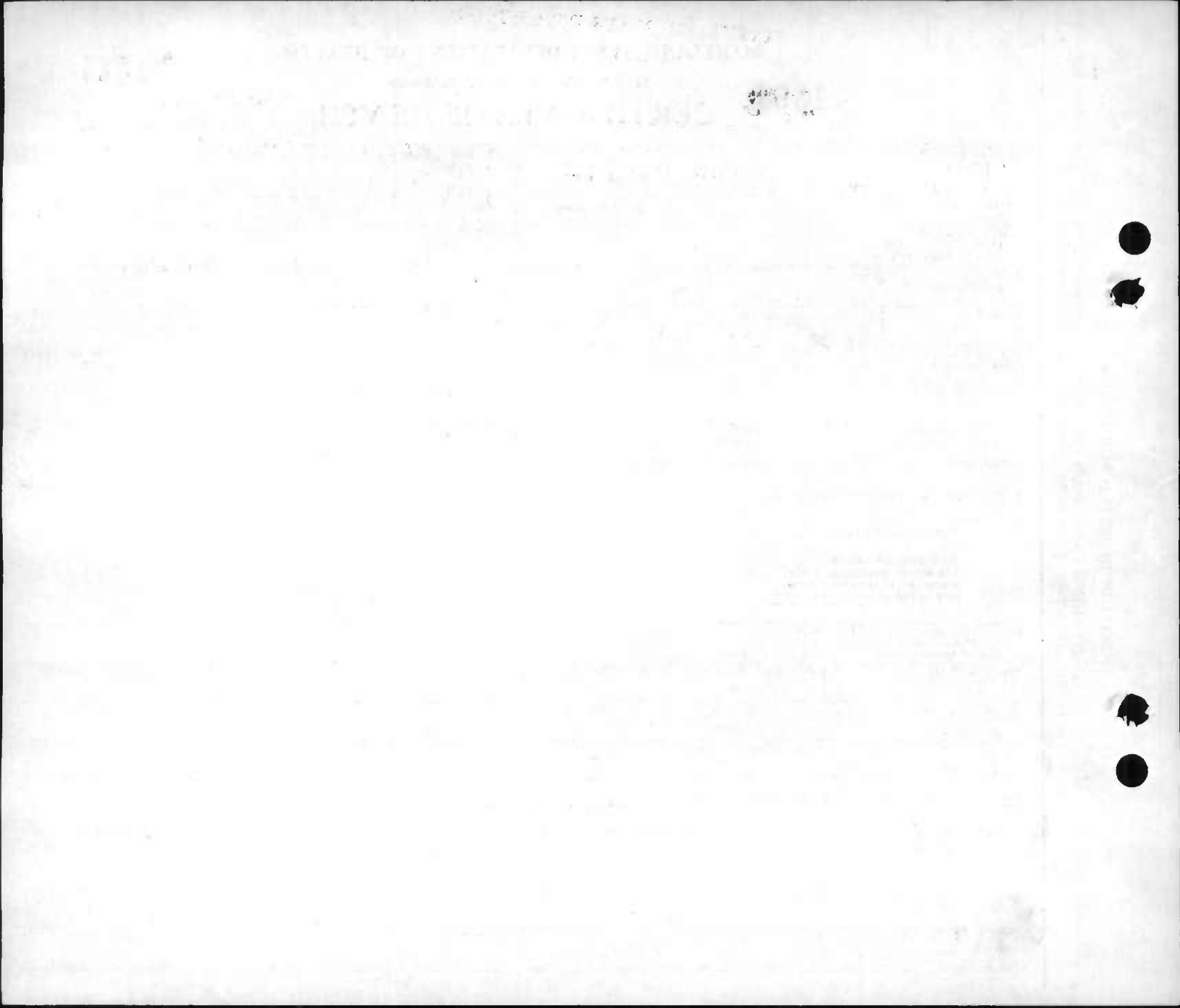
## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>ANN ARUNDEL</u> - MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>ANN ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover - Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover - Md.</u>	
TOWN <u>Hanover - Md.</u>		TOWN <u>Hanover - Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Stoney Run Road</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Julia</u>	<u>ANN</u>	<u>MARSHALL</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Feb.</u>	<u>24</u>	<u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct 17 - 78</u>
9. AGE last birthday	If under 1 year	If under 24 hrs.	
<u>77</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>Lancaster - Pa.</u>	<u>U.S.A</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<u>John Bauer</u>	<u>Pickensberger</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT	
		<u>Margaret Cosens (Daughter)</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>MYOCARDIAL INFARCTION</u>			<u>30 MIN.</u>
Antecedent cause(s) (b) <u>HYPERTENSION</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIO SCLEROSIS</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10 Feb 56</u> , 19 <u>56</u> , to <u>10 Feb 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 Feb 56</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>George E. Ginnell</u>		ADDRESS <u>2777 N. Charles St. Baltimore, Md.</u>	DATE SIGNED <u>25 Feb 56</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 28 56</u>	<u>London Mt. Cem.</u>	<u>Fredesburg - Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2-27-56</u>	<u>Dr. W. Redner</u>	<u>Frederick J. J. - 5646</u>	<u>Castille Rd.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01325

## 1365 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena - Rt. 1 Box 170</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena - Rt. 1 Box 170</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Point</u>				STREET ADDRESS (If rural give location) <u>Long Point</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Theresa Elizabeth McCauley</u>				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>January 30, 1956</u>	9. AGE last birthday yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cecil McCauley</u>				14. MOTHER'S MAIDEN NAME <u>Christine Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Cecil McCauley Pasadena, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
774X IMMEDIATE CAUSE (A) <u>PULMONARY MYXOMA THROMBOEMBOLIC DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PREMATURITY</u>						<u>30 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>3:30 p.m.</u> 19 <u>Feb.</u> , to <u>1 Feb.</u> 19 <u>Feb.</u> , that I last saw the deceased alive on <u>1 Feb.</u> 19 <u>Feb.</u> , and that death occurred at <u>8:20 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Theresa McCauley</u>		M.D. <u>Cecil McCauley</u>		ADDRESS (Street, city, town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>2 Feb. 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Pasadena, Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. DeAlba</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Kingston</u>		ADDRESS <u>St. Mary's</u>	

2099181300

# 1204 CERTIFICATE OF DEATH

DATE OF DEATH

AT HOME OR IN A HOSPITAL

PLACE OF DEATH

MARYLAND

COUNTY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

BUREAU V. S.

FEB 2 1932

RECEIVED

DEPARTMENT OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01326

## 1320 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis,</u>				TOWN <u>Herold Harbor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DOA Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Crownsville Post Office</u>			
3. NAME OF DECEASED (Type or Print) <u>George W. McGee</u> (First) <u>W.</u> (Middle) <u>McGEE.</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>26</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 22, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quartermaster</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James G. McGee</u>				14. MOTHER'S MAIDEN NAME <u>Maria Taylor Alice Tudor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-6942</u>		17. INFORMANT & ADDRESS <u>Mrs Myrle M. McGee- Wife- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2fa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>John Hunt</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md</u> DATE SIGNED <u>2/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 25 56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR <u>2-28-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

# 1950 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO. 12

ATTEST: I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths.

REGISTRAR

DEPUTY REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

FEB 29 1956

RECEIVED

RECEIVED

NOTES: This certificate is to be filled out by the physician or other qualified person who attended the deceased or who was present at the time of death. It should be filled out as soon as possible after death and should be filed in the office of the Registrar of Deaths. The cause of death should be stated in full, including the immediate, intermediate, and remote causes. The date and place of death should be stated. The signature of the physician or other qualified person should be written in the space provided. This certificate is a legal document and its contents are subject to the laws of the State of Maryland.

1321

01327  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Box 161 RFD 4 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural, give location) <u>Winchester on the Severn</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>SUELLEN</u>		(Middle) <u>McGILLIVRAY</u>		(Last)		(Month) (Day) (Year) <u>February 13 19 56</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>August 12, 1948</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>2nd Grade</u>		9. AGE last birthday: <u>7</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
13. FATHER'S NAME: <u>Archie McGillivray</u>		14. MOTHER'S MAIDEN NAME: <u>Iris Precourt</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
- - - - - (If Yes, give war or dates of service) - - - - -		- - - - -		<u>Mr. Harchie McGillivray-Father-same as #2</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Crushing injuries to chest and Skull fracture</u>		DUE TO		<u>2 hours</u>	
Antecedent cause(s)		(b) _____		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Street</u>		21c. (City or town) (County) <u>02</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-13-56 8:55 a.m.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto and truck accident, on way to school</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED		2-13-56	
<u>Elmer G. Linhardt</u>		M. D.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 15, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>2-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED  
FEB 16 1956  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01328

1322 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		LENGTH OF STAY (in this place) <i>4 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>92 Homewood Convalescent Home</i>				STREET ADDRESS <i>1312 West St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Agnes M. Ebrath</i>				<b>4. DATE OF DEATH</b> (Month) <i>2</i> (Day) <i>15</i> (Year) <i>19 56</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Widowed</i>	<b>8. DATE OF BIRTH</b> <i>Unknown 1882</i>	<b>9. AGE last birthday</b> <i>73</i> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>house work</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>at home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Baltimore</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>Michael Cooney</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>unknown</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>✓</i>		<b>16. SOCIAL SECURITY NO.</b> <i>✓</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mr. T. Leo Cooney 303 So. Gilmer St.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <i>Cerebral Vascular Accident</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>24 Hours</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Arteriosclerosis</i>				<i>unknown</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. _____		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>DEC 14 1954</i>, to <i>15 FEB 1956</i>, that I last saw the deceased alive on <i>14 FEB 1956</i>, and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Eduard A. Beck</i> M.D. <i>4 Southgate Lane Annapolis</i>				<b>DATE SIGNED</b> <i>2/15/56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE (THEREOF)</b> <i>2/17/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>New Cathedral Cem.</i>		<b>LOCATION (City, town, or county)</b> <i>4300 Old Frederick Rd. St.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>FEB 16 1956</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Wm. J. French</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John J. Cowan &amp; Son</i>		<b>ADDRESS</b> <i>Hollins</i>	

SMITHSONIAN INSTITUTION

RECEIVED  
FEB 17 1953  
BUREAU V. S.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIED

WIDOWED

SINGLE

DIVORCED

SEPARATED

UNKNOWN

OTHER

REMARKS

SIGNATURE

DATE

PLACE

TIME

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

NOSE

EARS

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

PELVIS

PERINEUM

ANUS

TESTES

PROSTATE

SEMINAL VESICLE

URETER

BLADDER NECK

URETHRA

SCROTUM

GLANS

FORESKIN

HYPOPHALLUS

CLITORIS

LABIA

VULVA

PERINEAL POCKET

HYMEN

HYMENAL RING

HYMENAL CLEFT

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01329

## 1323 CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		STATE <i>MD</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>		<i>5 yrs.</i>		TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General</i>				STREET ADDRESS (If rural give location) <i>610 Seom Ct.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>FREDERICK HERMAN MEENCH</i>				<i>FEB. 20 1956</i>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<i>Male</i>		<i>White</i>		<i>D</i>		<i>DEC. 11, 1890</i>	
						<b>9. AGE last birthday</b> (Months) (Days) (Hours) (Min.)	
						<i>65 yrs.</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<i>MECHANIC</i>				<i>?</i>		<i>NEW JERSEY</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>FREDERICK HERMAN MEENCH</i>				<i>Lydia Reed</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<i>NO</i>				<i>?</i>		<i>DAUGHTER - KATHLEEN - SAME</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>241X IMMEDIATE CAUSE (A)</b> <i>Branchial asthma</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>16 hrs.</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <i>10 yrs.</i>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Bilateral pulmonary Tuberculosis</i>						<i>10 yrs.</i>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>December 19 55</i>, to <i>Feb 20</i>, 19<i>56</i>, that I last saw the deceased alive on <i>Feb 19</i>, 19<i>56</i>, and that death occurred at <i>3:00</i> P.M. from the causes and on the date stated above. <i>2/20/56</i></b>							
<b>SIGNATURE</b> <i>John B. Hiderman</i>				<b>ADDRESS</b> (Street, city, town, state) <i>M.D. 90 Cathedral St. Annapolis, Md.</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>2-23-56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Columbus Cemetery</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Columbus, N.J.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>J. O. Daniel</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>HOPPING FUNERAL HOME</i>		<b>ADDRESS</b> <i>ANNAPOLIS, MD.</i>	
<b>DATE</b> <i>2-21-56</i>							

CERTIFICATE OF DEATH

01880

21

A. DEATH NOTIFICATION (NAME OF DECEASED)

DECEASED

PLACE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

BUREAU V. S.

FEB 23 1956

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

22

1. NAME OF DECEASED (Type or Print) <b>ALEXANDER NERO</b>			2. DATE OF DEATH <b>2-23-56</b>		
3. PLACE OF DEATH: <b>3 Mil. N. of Odenton Station</b> <b>A. Baltimore City, Maryland on P.R.R.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <b>STATE</b> <b>New Jersey</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Donne Duindel County</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Trenton</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1150 Deutz Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>2/4/32</b>		9. AGE (in years last birthday) <b>23 (23)</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			11. BIRTHPLACE (State or foreign country) <b>Trenton, N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Alexander Nero</b>			14. MOTHER'S MAIDEN NAME <b>Sichik</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alexander Nero</b>
			ADDRESS <b>1150 Deutz Ave, Trenton, N. J.</b>		

18. <b>CAUSE OF DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Extensive traumatic injuries of chest with crushing injury of chest</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Avulsion of right arm</b>		
DUE TO <b>Multiple fractures involving the femur, left ulna and humerus.</b>		
DUE TO <b>Train derailed: 2-23-56 5:26 P.M.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Injury occurred 3 miles north of Odenton Sta. on P.R.R.</b>		

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Partial</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2-23-56 5:26 P.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Train derailed</b>		
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
23A. SIGNATURE <i>[Signature]</i>		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR	23C. DATE SIGNED <b>2-24-56</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>2/28/56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S GREEK CATHOLIC</b>	24D. LOCATION (City, town, or county) (State) <b>TRENTON, N. J.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>FEB 28 1956</b>		25. FUNERAL DIRECTOR <b>Hopping &amp; Kirkley, Glen Burnie, Md</b>		

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and leg

The

BUREAU V. S.

MAR 1 1956

RECEIVED

1367

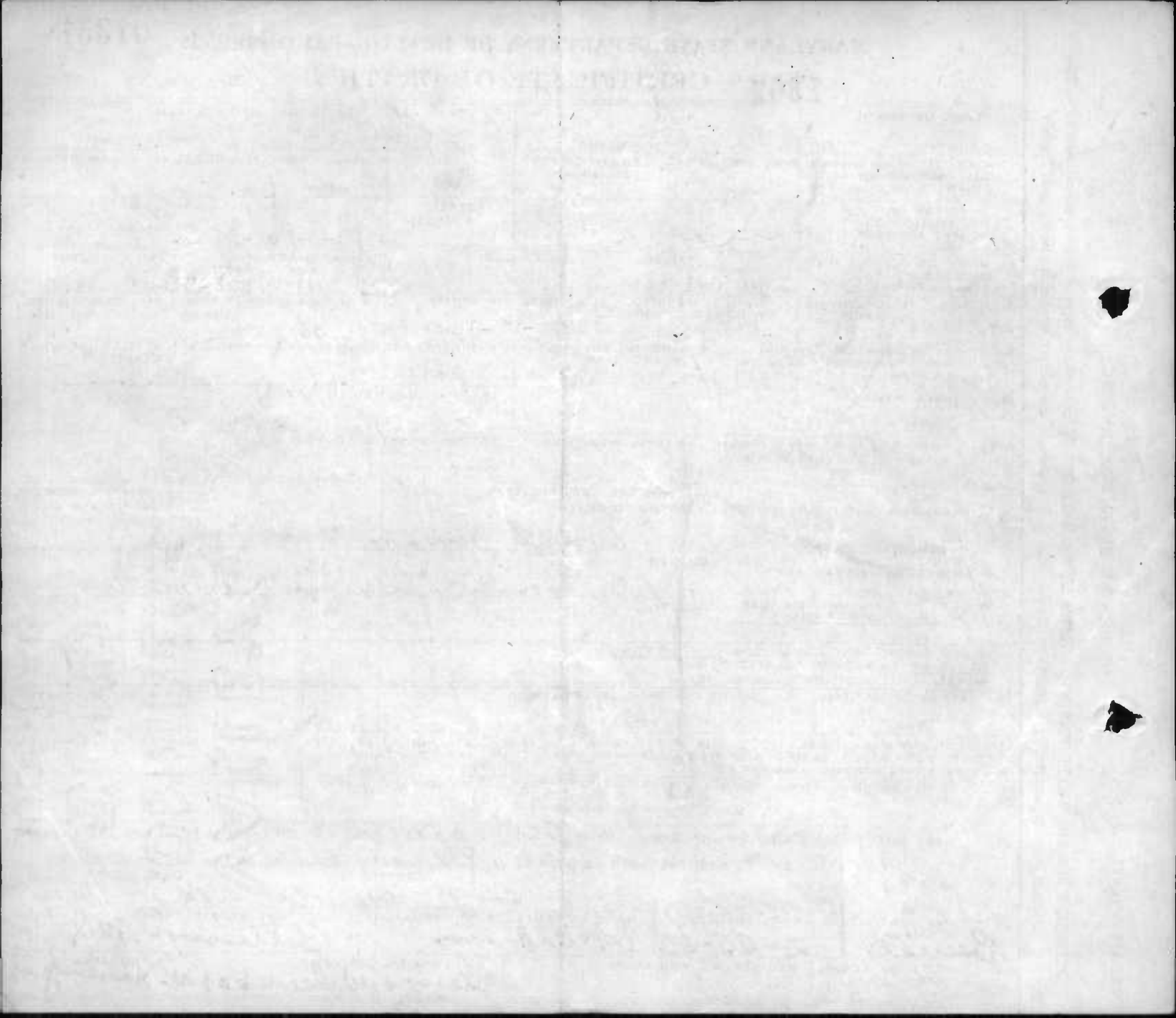
## CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Arrundle</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Arrundle</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Savern Md.</u>		<u>5 Yrs.</u>		TOWN <u>Savern Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route-2-Box-54 A.</u>				STREET ADDRESS (If rural give location) <u>Route-2-Box-54 A.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Rev. John Oglesby				DATE OF DEATH: <u>Feb-21-</u> <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Sept-27-1899</u>	
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life. If retired, so state) <u>Cement Finisher</u>		11. BIRTHPLACE (State or foreign country): <u>Calrie S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Oglesby</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Oglesby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Bessie Oglesby Same</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Coronary Occlusion</u>							
ANTECEDENT CAUSE (B) <u>Anterior wall Myocardial Infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0 none</u>				19B. MAJOR FINDINGS OF OPERATION: <u>none</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 11, 1956</u> to <u>Feb 20, 1956</u> that I last saw the deceased alive on <u>Feb 20, 1956</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. Roderick Shipley</u>				ADDRESS <u>721 Medical Arts Bldg Baltimore</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>2-25-56</u>		<u>mt arbutum</u>		<u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>February 25, 1956</u>				REGISTRAR'S SIGNATURE <u>R.W.</u>			
24. FUNERAL DIRECTOR				ADDRESS			
<u>Chas. O. Wilson</u>				<u>601 W. Lombard St</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1368 CERTIFICATE OF DEATH

Items 11,12,10a, 13,14 Film 193 2-27-56 et

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

COUNTY

ANNE ARUNDEL MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN RURAL - LAKE SHORE 26 YEARS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

MOUNTAIN ROAD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MARYLAND

COUNTY

A.A.

CITY (If outside corporate limits, write RURAL, and give nearest town)

OR TOWN RURAL - LAKE SHORE X

STREET ADDRESS (If rural give location)

MOUNTAIN ROAD

## 3. NAME OF DECEASED:

(First)

EDITH

(Middle)

JESSIMINE

(Last)

PHELPS

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

DEATH: FEB. 17 1956

## 5. SEX:

FEMALE

## 6. COLOR OR RACE:

WHITE

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

## 8. DATE OF BIRTH:

9. AGE last birthday: 79 yrs. Months Days Hours Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Housewife- Home

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

A. A. Co., Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Elijah Joyce

## 14. MOTHER'S MAIDEN NAME:

Edith J. Phumphrey

## 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
Immediate cause

(a) DUE TO

CORONARY THROMBOSIS

Antecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) DUE TO

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

(c)

Interval Between Onset And Death

IMMEDIATE

20 YEARS

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

VIRUS PNEUMONIA

2 WEEKS

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

## 22. I hereby certify that I attended the deceased from MAY, 1952, to FEB. 17, 1956, that I last saw the deceased

alive on FEB. 14, 1956, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Brady Smith M.D.

Riviera Beach, Md.

2/17/56

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB. 20, 1956

J. W. Hedrick

A. B. Howard

Broom 1400 S Charles St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

100



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1824

## CERTIFICATE OF DEATH

01333

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>An. A. Co.</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>A. A. Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>32 Parole St</i>				STREET ADDRESS (If rural give location) <i>32 Parole St</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Richard</i> (First) <i>Phillips</i> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <i>2</i> (Day) <i>6</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>4-4-1898</i>	9. AGE last birthday <i>57</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION, (Give kind of work done during most of working life, even if retired) <i>Laborer</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Richard Phillips</i>				14. MOTHER'S MAIDEN NAME <i>Mary Louise Gray</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-14-0496</i>		17. INFORMANT & ADDRESS <i>Eva Phillips - 32 Parole St, Anne. Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
332 X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>2-5-56</i> , <b>19</b> , <b>to</b> <i>2-6-56</i> , <b>19</b> , <b>that I last saw the deceased alive on</b> <i>2-5-56</i> , <b>19</b> , <b>and that death occurred at</b> <i>3-5</i> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <i>W. T. Carr</i> <b>ADDRESS</b> (Street, city, town, state) <i>62 Chestnut St</i> <b>DATE SIGNED</b> <i>2-7-56</i> <b>M.D.</b> <i>62 Chestnut St</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-9-56</i>		NAME OF CEMETERY OR CREMATORY <i>Fowler</i>		LOCATION (City, town, or county) (State) <i>Best Gate, Md.</i>	
24. REC'D BY REGISTRAR <i>W. T. Carr</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr</i>		ADDRESS <i>Annapolis, Md.</i>	
DATE <i>2-15-1956</i>							

01833

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

# CERTIFICATE OF DEATH

AGE - 101 M

1. NAME OF DEATH

MARYLAND

2. SEX - M  
3. DATE OF BIRTH -  
4. PLACE OF BIRTH -

5. DEATH -

6. MEDICAL CERTIFICATION

BUREAU V. S.

FEB 17 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01334

## 1325 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH Anne COUNTY <u>Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 TOWN <u>Annapolis</u> LENGTH OF STAY (in this place) <u>9 DAYS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 <u>Anne Arundel Gen Hosp</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Severn</u> STREET ADDRESS (If rural give location) <u>Delmont Severn</u>			
3. NAME OF DECEASED (Type or Print) Emma (First) (Middle) (Last) <u>PRINCE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 15 1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>(Widowed)</u>	8. DATE OF BIRTH <u>May 4, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own - None</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Reese</u>			14. MOTHER'S MAIDEN NAME <u>Annie</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. M. C. Graham 209 Sycamore Rd. Linthicum Heights Md</u>			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u>					<u>6 Hr</u>		
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 42459 (B) <u>ARTERIO-SCLEROSIS</u>							
(C) <u>Coronary Artery Disease, Fractured Lumbar Spine</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Delmont, Severn</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>56 FEB 4</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>FELL AT HOME</u>			
22. I hereby certify that I attended the deceased from <u>6 FEB 1956</u> to <u>15 FEB 1956</u> that I last saw the deceased alive on <u>15 FEB 1956</u> and that death occurred at <u>6:07 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Handman</u>		ADDRESS (Street, city, town, state) <u>96 Cathedral St Annapolis</u>		DATE SIGNED <u>2-15-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb-18-1956</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>			
24. REC'D BY REGISTRAR <u>555 21 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>TR King</u>			
				ADDRESS <u>140</u>			

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Central Intelligence Agency

11/12/1911

STUREAU V. S.

FEB 21 1953

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## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>130 PRINCE GEORGE ST</u>				d. STREET ADDRESS <u>130 PRINCE GEORGE ST</u>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last <u>REVEHL</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/29/1882</u> 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BOOKKEEPER</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>MARTIN FANNEN REVEHL</u>				14. MOTHER'S MAIDEN NAME <u>SUSANAH SANDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-05-0711</u>		17. INFORMANT Address <u>MRS CLINTON C. MOSS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>421.4</u> DUE TO (b) <u>Congestive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Endocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>About 1 yr.</u> <u>Several yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan 4</u> , 1956, to <u>Feb 25</u> , 1956, that I last saw the deceased alive on <u>Jan 26</u> , 1956, and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Oliver Purvis</u> M.D.				ADDRESS (Street, city or town, state) <u>40 Franklin St., Annapolis Md.</u> DATE SIGNED <u>2/24/56</u>			
PHYSICIAN'S NAME (Type) <u>J. Oliver Purvis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Gorton &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb. 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. OCCUPATION</p>	
<p>11. EDUCATION</p>		<p>12. RELIGION</p>	
<p>13. MARRIAGE HISTORY</p>		<p>14. SOCIAL HISTORY</p>	
<p>15. FAMILY HISTORY</p>		<p>16. OTHER INFORMATION</p>	
<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. DATE OF SIGNATURE</p>		<p>20. PLACE OF SIGNATURE</p>	

BUREAU V. S.

MAR 2 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1369 CERTIFICATE OF DEATH

01336

Reg. Dist. No. 25

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>a.a.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>50</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>50</i>		TOWN <i>50</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5428 WASENA AVE</i>				STREET ADDRESS (If rural give location) <i>5428 WASENA AVE</i>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Clarence Rhinehardt</i>				<i>Feb. 5, 1956</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>	8. DATE OF BIRTH <i>3/5/1900</i>	9. AGE last birthday <i>55</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clance op.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Swig.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unk.) (If Yes, give war or dates of service) <i>Yes</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Family - Same</i>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
163X IMMEDIATE CAUSE (A) <i>Cancer of lung</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>April 1953</i> , to <i>February 1956</i> , that I last saw the deceased alive on <i>Feb. 5, 1956</i> , and that death occurred at <i>8A</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Regene Selby</i>				ADDRESS (Street, city, town, state) <i>3904 S. Hanover St., Zone 25</i>		DATE SIGNED <i>2-6-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>15</i>		DATE THEREOF <i>2/6/56</i>		NAME OF CEMETERY OR CREMATORY <i>154110</i>		LOCATION (City, town, or county) (State) <i>154110</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Ada Whitson</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>McLurey James How</i>		ADDRESS	
DATE <i>FEB 9 1956</i>							

# RECURRENCE

1. Name of patient: [illegible]  
 2. Address: [illegible]  
 3. Date of birth: [illegible]  
 4. Sex: [illegible]  
 5. Race: [illegible]  
 6. Religion: [illegible]  
 7. Occupation: [illegible]  
 8. Education: [illegible]  
 9. Marital status: [illegible]  
 10. Date of admission: [illegible]  
 11. Date of discharge: [illegible]  
 12. Date of death: [illegible]  
 13. Cause of death: [illegible]  
 14. Place of death: [illegible]  
 15. Date of burial: [illegible]  
 16. Place of burial: [illegible]  
 17. Date of autopsy: [illegible]  
 18. Place of autopsy: [illegible]  
 19. Date of necropsy: [illegible]  
 20. Place of necropsy: [illegible]

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1336

1. Name of patient: [illegible]		2. Address: [illegible]	
3. Date of birth: [illegible]		4. Sex: [illegible]	
5. Race: [illegible]		6. Religion: [illegible]	
7. Occupation: [illegible]		8. Education: [illegible]	
9. Marital status: [illegible]		10. Date of admission: [illegible]	
11. Date of discharge: [illegible]		12. Date of death: [illegible]	
13. Cause of death: [illegible]		14. Place of death: [illegible]	
15. Date of burial: [illegible]		16. Place of burial: [illegible]	
17. Date of autopsy: [illegible]		18. Place of autopsy: [illegible]	
19. Date of necropsy: [illegible]		20. Place of necropsy: [illegible]	

BUREAU V. S.

FEB 10 1956

RECEIVED

1370

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01337  
Reg. Dist.

No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN <u>P.O. Glen Burnie</u>		<u>Few minutes.</u>		TOWN <u>P.O. Glen Burnie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In Stony Creek off View Point Shore.</u>				STREET ADDRESS (If rural, give location) <u>Bright Water Beach</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>Ralph William Robinson</u>		<u>February 14th</u>		<u>19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1/8/03</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Electrician (Merchant Marine.)</u>		<u></u>		<u>Grafton, W.Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Robinson</u>				<u>Martha Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>236-20-5317</u>		<u>Mrs. Mary Robinson (Wife)</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden	
<p>9238</p> <p>Immediate cause (a) <u>Accidental Drowning</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, bus, etc.) INJURY <u>Stony Creek</u>		21c. (City or town) (County) (State)	
		<u>Off View Point Shore, A.A.</u>		<u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2/14/56 5.10 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Drowning</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER			
<u>Kustav H. Paerbert</u>		DEPUTY MEDICAL EXAMINER			
		ASSISTANT MEDICAL EXAM. <u>2/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Feb. 21/56</u>		<u>Balto. Nat'l. Cem.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>2-21-56</u>		<u>L. J. Allen</u>		<u>R. V. Singleton</u>	
				ADDRESS <u>Glen Burnie, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. B.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01338

## 1371 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville (RFD)</u>		<u>Life</u>		TOWN <u>Millersville (RFD)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crain Highway</u>				STREET ADDRESS <u>Crain Hwy</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Mary</u> (Middle) <u>C.</u> (Last) <u>Sappington</u>				(Month) <u>Feb</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>June 28, 1859</u>	9. AGE last birthday <u>96</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>A-B-Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>1425 Nat Pumpbery, Millersville, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>				5 yrs.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Infected Arm</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Feb. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 15</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James S. Billingslea</u>		M.D. <u>108 Central Ave Glen Burnie Md. 74114</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 21 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>T. J. Singler</u>		ADDRESS <u>Glen Burnie, Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

FILE NO.

1. DEATH CERTIFICATE NUMBER ON RECORD

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF VENDOR

19. SIGNATURE OF SELLER

20. SIGNATURE OF BUYER

21. SIGNATURE OF TRANSFEREE

22. SIGNATURE OF TRANSFEROR

23. SIGNATURE OF ASSIGNEE

24. SIGNATURE OF ASSIGNOR

25. SIGNATURE OF ENDORSEMENT

26. SIGNATURE OF COUNTERSIGNED

27. SIGNATURE OF RECEIVED

28. SIGNATURE OF PAID

29. SIGNATURE OF DEPOSITED

30. SIGNATURE OF WITHDRAWN

31. SIGNATURE OF CANCELLED

32. SIGNATURE OF EXPIRED

33. SIGNATURE OF REVOKED

34. SIGNATURE OF RESCINDED

35. SIGNATURE OF ANULLED

36. SIGNATURE OF REPEALED

37. SIGNATURE OF REPEALED

38. SIGNATURE OF REPEALED

39. SIGNATURE OF REPEALED

40. SIGNATURE OF REPEALED

41. SIGNATURE OF REPEALED

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51. SIGNATURE OF REPEALED

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55. SIGNATURE OF REPEALED

56. SIGNATURE OF REPEALED

57. SIGNATURE OF REPEALED

58. SIGNATURE OF REPEALED

59. SIGNATURE OF REPEALED

60. SIGNATURE OF REPEALED

BUREAU V. R.

FEB 21 1956

RECEIVED

2000-10-10

01339

## 1377 CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 3, Film G193 3-7-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY		TOWN		STATE		COUNTY	
Anne Arundel		Annapolis		Maryland		AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
10 TOWN		Annapolis		10 Anna polis		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
57 USNH, Annapolis, Md				520 Horn Point			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) last (Middle) first (Last) first				(Month) (Day) (Year)			
SATTMARY, (n)				February 27 56			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
F		Cau		M		7-22-82	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
72 yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				-		Denmark	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
US				Jens Christain Lykke			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			
Kirsten Grandslow				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS			
				USNH Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 Days	
IMMEDIATE CAUSE (A)						Infarct, Cerebral #332	
ANTECEDENT CAUSE(S) DUE TO						Cerebral Arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						Hypertensive Cardiovascular Disease	
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 25 February 56, to 27 February 56, that I last saw the deceased alive on 27 February 56, and that death occurred at 3:50a M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
W. K. MOXON CDR MC USN				DATE SIGNED			
M.D. U.S. Naval Hospital, Annapolis, Md.				27 Feb. 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		27 Feb 56		National Cem		Annapolis Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Feb. 29, 1956		10 - U. S. Navy		John M. Taylor Sons		Annapolis Md	

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF SURVIVORS

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF DECEASED

19. SIGNATURE OF SURVIVORS

20. SIGNATURE OF DECEASED

21. SIGNATURE OF SURVIVORS

22. SIGNATURE OF DECEASED

23. SIGNATURE OF SURVIVORS

24. SIGNATURE OF DECEASED

25. SIGNATURE OF SURVIVORS

BUREAU V. 2

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01340

1372 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Prince George's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crownsville</b>		LENGTH OF STAY (in this place) <b>5yrs. 9mos. 21days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Upper Marlboro</b>		<b>16X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>10 Crownsville State Hospital</b>				STREET ADDRESS (If rural give location) <b>None listed</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>John Savoy</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>2 23 1956</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>Not given</b>		<b>9. AGE last birthday</b> <b>53?</b> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.) <b>— — — —</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>	
<b>13. FATHER'S NAME</b> <b>Not listed</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Not listed</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>(If Yes, give war or dates of service)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Records</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>422.1 IMMEDIATE CAUSE (A)</b> <b>Kachexia</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Myocardial degeneration</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Arteriosclerosis</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Mental Deficiency with Psychosis</b>						<b>Life</b>	
<b>19a. DATE OF OPERATION</b> — — — —		<b>19b. MAJOR FINDINGS OF OPERATION</b> — — — —				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> — — — —		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> — — — —			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> — — — —		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b> — — — —			
<b>22. I hereby certify that I attended the deceased from 1/5, 1955, to 2/23, 1956, that I last saw the deceased alive on 2/23, 1956, and that death occurred at 3:25a.m. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Hedward Heard Reiser</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Crownsville, Md.</b>		<b>DATE SIGNED</b> <b>2/23/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>2/26/56</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Simon</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Croom, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 28 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <i>26. M. Jayces</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Rollins Funeral Home</i> <b>ADDRESS</b> <b>4339 Hunt Pl. W E</b>			

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Smith		45		Male		White		Feb 23 1956		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Usual Residence		Place of Birth		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial	
Teacher		High School		Married		Catholic		123 Main St		New York		Jan 15 1911		Jan 20 1956		Jan 25 1956		Jan 28 1956	
Usual Residence		Place of Birth		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Necropsy	
123 Main St		New York		Jan 15 1911		Jan 20 1956		Jan 25 1956		Jan 28 1956		Jan 30 1956		Jan 31 1956		Feb 1 1956		Feb 2 1956	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist	
Feb 23 1956		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Usual Residence		Place of Birth		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Necropsy	
123 Main St		New York		Jan 15 1911		Jan 20 1956		Jan 25 1956		Jan 28 1956		Jan 30 1956		Jan 31 1956		Feb 1 1956		Feb 2 1956	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist	
Feb 23 1956		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
FEB 23 1956  
BUREAU V. 2

1. If the deceased was a resident of the State of Maryland at the time of death, the death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

2. If the deceased was a non-resident of the State of Maryland at the time of death, the death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

3. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

4. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

5. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

6. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

7. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

8. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

9. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

10. The death certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1328 CERTIFICATE OF DEATH

01342

Reg. Dist. No. 21

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>AA</u>		CITY (if outside corporate limits, write RURAL and give nearest town)		CITY (if outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Severn Md</u>		LENGTH OF STAY (in this place) <u>8 mo.</u>		TOWN <u>Severn, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital, Annapolis, Md.</u>				STREET ADDRESS (if rural give location) <u>New Cut Road, Severn, Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Frank (N) SHAMBURGER</u>				<u>February 10 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>M</u>	<u>C</u>	<u>M</u>	<u>8-14-98</u>	<u>57</u> yrs.	Months Days	Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.N.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Miss.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>
<b>13. FATHER'S NAME</b> <u>John Wesley SHAMBURGER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Hattie Barlow</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes 1917-36:1941-45</u>			<b>16. SOCIAL SECURITY NO.</b> <u>212 05 9802</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>U.S. Naval Hospital, Records</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>523.0 IMMEDIATE CAUSE (A)</b> <u>ASPHYXIA #795</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Terminal</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>SUPPURATION, LUNG, CHRONIC #521</u>						<u>8 mo.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b> <u>SILICOSIS, SILICOTIC OCCUPATIONAL # 523</u>						<u>8 mo.</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8-16-1955, to 2-10-1956, that I last saw the deceased alive on 2-10-1956, and that death occurred at 4:45 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>R.K. MOXON CDR MC USN</u>				<b>ADDRESS</b> (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> <b>DATE SIGNED</b> <u>2-11-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 13, 56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Feb. 13, 56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOPPING FUNERAL HOME</u> <b>ADDRESS</b> <u>ANNAPOLIS, MD.</u>			

# CERTIFICATE OF DEATH

1943

1943

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF COUNTY JUDGE

25. SIGNATURE OF COUNTY SHERIFF

26. SIGNATURE OF COUNTY CLERK

27. SIGNATURE OF COUNTY JUDGE

28. SIGNATURE OF COUNTY SHERIFF

29. SIGNATURE OF COUNTY CLERK

29. SIGNATURE OF COUNTY JUDGE

30. SIGNATURE OF COUNTY SHERIFF

31. SIGNATURE OF COUNTY CLERK

32. SIGNATURE OF COUNTY JUDGE

33. SIGNATURE OF COUNTY SHERIFF

34. SIGNATURE OF COUNTY CLERK

35. SIGNATURE OF COUNTY JUDGE

36. SIGNATURE OF COUNTY SHERIFF

37. SIGNATURE OF COUNTY CLERK

38. SIGNATURE OF COUNTY JUDGE

39. SIGNATURE OF COUNTY SHERIFF

40. SIGNATURE OF COUNTY CLERK

41. SIGNATURE OF COUNTY JUDGE

42. SIGNATURE OF COUNTY SHERIFF

43. SIGNATURE OF COUNTY CLERK

44. SIGNATURE OF COUNTY JUDGE

BUREAU V. S.

FEB 16 1956

RECEIVED

INVESTIGATION

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01343

1329

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MAGothy Beach</u>		(If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place) <u>7 days</u>		STREET ADDRESS <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gen. Hosp Annapolis</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>George Wesley Sheckels</u>				<b>4. DATE OF DEATH</b> (Month) <u>Feb</u> (Day) <u>24</u> (Year) <u>1957</u>			
<b>5. SEX</b> <u>M.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>17 Feb 1882</u>	<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>		<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fishing</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTO, MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Lusby</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-34-6250</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MAGothy Beach</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>610X IMMEDIATE CAUSE</b> (A) <u>① Circulatory Collapse.</u>							
<b>ANTECEDENT CAUSE(S)</b> DUE TO <u>② Generalized Bleeding.</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO <u>Tendency &amp; Postoperative shock.</u>							
<b>STATING UNDERLYING CAUSE LAST.</b> (C) <u>③ Generalized Arteriosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>19 Feb 57</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>ENLARGED Prostate</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u></u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>July 4, 1955</u> , to <u>24 Feb 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 Feb 57</u> , 19 <u>57</u> , and that death occurred at <u>4:40</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Hahn</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Severna Park, Md 24 Feb 57</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Funeral</u>		<b>DATE THEREOF</b> <u>Feb-27/57</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Bethesda, MD</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Feb 28 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Nov. J. French</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert J. ...</u>		<b>ADDRESS</b>	

1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

Form No. 1

1. DEATH RECORDING INFORMATION

2. DEATH INFORMATION

3. PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

REGISTERED

1. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

2. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

3. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

4. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

5. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

6. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

7. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

8. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

9. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

10. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, for the year 1956.

BUREAU V. S.

FEB 28 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(41)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01344

1373 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>Md</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hanover Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hanover Rural</u>			
TOWN <u>Hanover Rd</u>				TOWN <u>Hanover Rd</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanover Rd</u>				STREET ADDRESS (If rural give location) <u>Hanover Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Chas Spruell</u>				<u>Feb. 3 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Col</u>	<u>Widowed</u>	<u>Jan 1-1887</u>	<u>69</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
<u>Janitor</u>				<u>Painting &amp; Paper Co</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Kingston N.C.</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Harry Spruell</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.			
<u>no</u>				<u>217-05-1015</u>			
17. INFORMANT'S ADDRESS:							
<u>Chas Spruell, Box 2, Hanover, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cancer of Lungs</u>						<u>6 mo</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>" of Liver</u>						<u>2 mo</u>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 18, 1955</u> , to <u>Feb 3, 1956</u> that I last saw the deceased alive on <u>Feb 3, 1956</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>B. B. Bumbrough</u>				DATE SIGNED <u>2/3/56</u>			
M. D. <u>5608 main St</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>St. J. Rest</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Feb 6, 1956</u>				REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>			
				MUNICIPAL DIRECTOR <u>1031 David Will Ave</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL:

The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01345

1374

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Pasadena P.F.D.</i>		<i>8 years</i>		TOWN <i>Pasadena P.F.D.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mountain Road</i>				STREET ADDRESS (If rural give location) <i>Mountain Road</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>SARAH LOUISA STALLINGS</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Feb. 20, 1956</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>		8. DATE OF BIRTH <i>OCT. 10-1870</i>	
				9. AGE last birthday <i>85</i> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housework (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John F. Ellison</i>				14. MOTHER'S MAIDEN NAME <i>Sarah E. Osborne</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>William Stallings Mountain Rd Pasadena P.D., Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
450.0 IMMEDIATE CAUSE (A) <i>Acute pulmonary edema</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>						<i>Not known</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Fracture of left tibia</i>						<i>2 months</i>	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)						21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb. 20, 1956</i> to <i>Feb. 20, 1956</i> , that I last saw the deceased alive on <i>Feb. 20, 1956</i> , and that death occurred at <i>5:30 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>R.M. McLaughlin</i>				ADDRESS (Street, city, town, state) <i>Pasadena, Md.</i>		DATE SIGNED <i>Feb. 20, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Feb. 23/56</i>		NAME OF CEMETERY OR CREMATORY <i>Magothy Church Cem</i>		LOCATION (City, town, or county) (State) <i>Magothy, A.A.C., Maryland</i>	
24. REC'D BY REGISTRAR <i>Feb 24 1956</i>		REGISTRAR'S SIGNATURE <i>Louis J. Adallas</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Smith</i>		ADDRESS <i>Glen Burnie, MD.</i>	

TO ATTENDING PHYSICIAN OR HOSPITAL:

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR:

The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

death certificate assembly should be detached for use as a burial transit permit.

BUREAU A. S.

FEB 24 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1330

## CERTIFICATE OF DEATH

01346

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Franklin Street</u>				STREET ADDRESS <u>213 Claude Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOSEPH</u> <u>ELMER</u> <u>TAYMAN</u>				<b>4. DATE OF DEATH</b> (Month) <u>FEBRUARY</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 20, 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Albert Tayman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sewell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>212-10-2816</u>		17. INFORMANT & ADDRESS <u>Mrs Marie Dixon- Daughter- same as # 2</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
410X IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 3 1/2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>						<u>Several yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Mitral Stenosis</u>						<u>yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10<sup>th</sup></u> , 19 <u>56</u> , to <u>Feb 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>56</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Elizur Purvis</u>				ADDRESS (Street, city, town, state) <u>M.D. 40 Franklin St Annapolis Md</u>		DATE SIGNED <u>2/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 12, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
24. REC'D BY REGISTRAR <u>L-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME - ANNAPOLIS, MD</u>	

CERTIFICATE OF DEATH

13

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

BUREAU V. S.

FEB 16 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01347

1375

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>B.A.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>B.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		LENGTH OF STAY (in this place) <u>years.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		TOWN <u>50</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 EDGEVALE RD.</u>				STREET ADDRESS (If rural give location) <u>113 EDGEVALE RD.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth A. Thomas</u>				<b>4. DATE OF DEATH</b> (Month) <u>2</u> (Day) <u>18</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>M.</u>	<b>8. DATE OF BIRTH</b> <u>4-1-69</u>	<b>9. AGE last birthday</b> <u>86</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>PA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>? Robinson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>? Anderson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Family - Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>443x cardiac failure</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>hypertensive myocardial infarct</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <b>DUE TO (B)</b>							
<b>DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan, 1954</u> , <b>to</b> <u>2-8, 1956</u> , <b>that I last saw the deceased alive on</b> <u>2-8, 1956</u> , <b>and that death occurred at</b> <u>6:27P</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Eugene Dwyer</u>				<b>DATE SIGNED</b> <u>2-10-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>B</u>				<b>DATE THEREOF</b> <u>2/11/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>1700 Edgewood</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b> <u>Eda Whitson</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCully Funeral Homes</u>	
<b>DATE</b> <u>Feb. 14, 1956</u>				<b>ADDRESS</b> <u>3904 S. Hanover St.</u>			

# NOTICES

1. A notice of death must be filed with the Registrar of Births and Deaths within a period of 21 days of the death. If the death is reported to the Registrar by a person other than the informant, the Registrar may require the informant to produce evidence of the death. If the Registrar is satisfied that the death has occurred, he will issue a certificate of death. If the Registrar is not satisfied, he may require the informant to produce evidence of the death. If the Registrar is not satisfied, he may require the informant to produce evidence of the death. If the Registrar is not satisfied, he may require the informant to produce evidence of the death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased person as ascertained

MARYANN

2. Place of birth

3. Date of birth

4. Sex

5. Date of death

6. Cause of death

7. Signature of Registrar

8. Signature of Informant

9. Signature of Medical Officer

10. Signature of Coroner

11. Signature of Police Officer

12. Signature of Health Officer

13. Signature of Social Worker

14. Signature of Nurse

15. Signature of Doctor

16. Signature of Pathologist

17. Signature of Forensic Scientist

BUREAU V. 3

FEB 14 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01348

F331

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Annapolis</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Annapolis</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1933 West St</i>				STREET ADDRESS (If rural give location) <i>1933 West St</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <i>Mary Elizabeth Thompson</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>2 9 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>5-31-1883</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annapolis, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles Carroll</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Bryan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Louis Thompson 1933 West St</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4431 IMMEDIATE CAUSE (A) <i>Cardiac Failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardio-Vascular Disease</i>				<i>2 yrs.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>2/15/56</i> , 19 <i>56</i> , <b>to</b> <i>2/19/56</i> , 19 <i>56</i> , <b>that I last saw the deceased</b> <b>alive on</b> <i>2/9/56</i> , 19 <i>56</i> , <b>and that death occurred at</b> <i>9:30 P</i> , M, <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <i>Theodore Johnson</i> M.D. <b>ADDRESS</b> (Street, city, town, state) <i>37 Labat Street Annapolis</i> <b>DATE SIGNED</b> <i>2/19/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-13-56</i>		NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		LOCATION (City, town or county) (State) <i>Annapolis, md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. J. ...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr</i>		ADDRESS <i>Annapolis</i>	
DATE <i>2/15/1956</i>							

# CERTIFICATE OF DEATH

Birth Date: May 1912

1. DECEASED PERSON'S NAME (Print or Type)

2. PLACE OF BIRTH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CLERK

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF CLERK

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF CLERK

29. SIGNATURE OF JURY

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CLERK

33. SIGNATURE OF JURY

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49. SIGNATURE OF JURY

50. SIGNATURE OF JUDGE

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF CLERK

53. SIGNATURE OF JURY

54. SIGNATURE OF JUDGE

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97. SIGNATURE OF JURY

98. SIGNATURE OF JUDGE

99. SIGNATURE OF SHERIFF

100. SIGNATURE OF CLERK

101. SIGNATURE OF JURY

102. SIGNATURE OF JUDGE

103. SIGNATURE OF SHERIFF

104. SIGNATURE OF CLERK

105. SIGNATURE OF JURY

106. SIGNATURE OF JUDGE

107. SIGNATURE OF SHERIFF

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109. SIGNATURE OF JURY

110. SIGNATURE OF JUDGE

111. SIGNATURE OF SHERIFF

112. SIGNATURE OF CLERK

113. SIGNATURE OF JURY

114. SIGNATURE OF JUDGE

115. SIGNATURE OF SHERIFF

116. SIGNATURE OF CLERK

117. SIGNATURE OF JURY

118. SIGNATURE OF JUDGE

119. SIGNATURE OF SHERIFF

120. SIGNATURE OF CLERK

BUREAU V. S.

FEB 17 1956

RECEIVED

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE AS A WITNESS OR AS THE SIGNATURE OF THE DECEASED OR AS THE SIGNATURE OF THE PHYSICIAN OR AS THE SIGNATURE OF THE CORONER OR AS THE SIGNATURE OF THE REGISTRAR OR AS THE SIGNATURE OF THE CLERK OR AS THE SIGNATURE OF THE JURY OR AS THE SIGNATURE OF THE JUDGE OR AS THE SIGNATURE OF THE SHERIFF OR AS THE SIGNATURE OF ANY OTHER OFFICIAL IS RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED AND FOR THE CORRECTNESS OF THE SIGNATURE. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE AS A WITNESS OR AS THE SIGNATURE OF THE DECEASED OR AS THE SIGNATURE OF THE PHYSICIAN OR AS THE SIGNATURE OF THE CORONER OR AS THE SIGNATURE OF THE REGISTRAR OR AS THE SIGNATURE OF THE CLERK OR AS THE SIGNATURE OF THE JURY OR AS THE SIGNATURE OF THE JUDGE OR AS THE SIGNATURE OF THE SHERIFF OR AS THE SIGNATURE OF ANY OTHER OFFICIAL IS RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED AND FOR THE CORRECTNESS OF THE SIGNATURE. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE AS A WITNESS OR AS THE SIGNATURE OF THE DECEASED OR AS THE SIGNATURE OF THE PHYSICIAN OR AS THE SIGNATURE OF THE CORONER OR AS THE SIGNATURE OF THE REGISTRAR OR AS THE SIGNATURE OF THE CLERK OR AS THE SIGNATURE OF THE JURY OR AS THE SIGNATURE OF THE JUDGE OR AS THE SIGNATURE OF THE SHERIFF OR AS THE SIGNATURE OF ANY OTHER OFFICIAL IS RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED AND FOR THE CORRECTNESS OF THE SIGNATURE.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1376 CERTIFICATE OF DEATH

01349

Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u>		STREET ADDRESS (If rural give location) <u>/</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Odessa</u> (Middle) <u>Patricia</u> (Last) <u>Thompson</u>				(Month) <u>Feb.</u> (Day) <u>14</u> (Year) <u>19 56</u>			
<b>5. SEX</b> <u>Fem</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Infant</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 16, 1956</u>		<b>9. AGE last birthday</b> yrs. <u>29</u>		<b>IF UNDER 1 YEAR</b> Months <u>29</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>George O. Thompson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Maxine Denny (or Dennis ?)</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Grandfather</u> <u>Frank Tongue, Shady Side, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>774X</b> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>						<u>1 Month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>not seen by me in life</u> to <u>19</u>, that I last saw the deceased alive on <u>19</u>, and that death occurred at <u>9:30 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>F. D. Hendrichs</u>		<b>DATE THEREOF</b> <u>2/15/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Matthews</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Shady Side Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> <u>Belle Dent</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Q. Zerkowicz</u>		<b>DATE SIGNED</b> <u>2-14-56</u>	
<b>DATE</b> <u>Feb 22-56</u>		<b>REGISTRAR'S SIGNATURE</b>		<b>ADDRESS</b>			

2063265263

# 1936 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

01330

Reg. Dist. No.

1. NAME OF DECEASED (GIVEN AND SURNAME)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF FUNERAL HOME

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL SOCIETY

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF INTERVIEWER

200133013301

BUREAU A. 2

FEB 27 1936

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1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01350

Item 21 Film G193 2-29-56

1377

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i> COUNTY <i>A. A.</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <i>Cumberland</i>		TOWN <i>Cumberland</i>	
TOWN <i>Shadyside</i>		<i>not at all</i>		STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>none</i>				HOSPITAL OR INSTITUTION OR STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>James Zingue</i>				<i>Feb. 12 1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>		8. DATE OF BIRTH <i>July 24, 1935</i>	
9. AGE last birthday <i>20</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cumberland Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Clinton Zingue</i>				14. MOTHER'S MAIDEN NAME <i>Martha Brent</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. <i>216327397</i>		17. INFORMANT & ADDRESS <i>Clinton Zingue, Cumberland, Md</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
823X IMMEDIATE CAUSE (A) <i>Fractured skull</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Automobile accident</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>Road</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>Churchton AA</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>2-11-56 12 M.</i>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Car skidded - hit tree threw him out</i>			
22. I hereby certify that I attended the deceased from <i>March 11, 19</i> , to <i>March 12, 19</i> , that I last saw the deceased alive on <i>March 12, 19</i> , and that death occurred at <i>12 noon</i> , from the causes and on the date stated above.							
SIGNATURE <i>Emily H. Urban acting coroner</i>				DATE SIGNED <i>2-12-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/15/56</i>		NAME OF CEMETERY OR CREMATORY <i>Chews</i>		LOCATION (City, town, or county) <i>West River Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Elvie West Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Benned Handouty</i>		ADDRESS <i>Belleville Md</i>	
DATE <i>2/12/56</i>							

BUREAU V. S.

FEB 15 1956

RECEIVED

## 1378 CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Ann Arundel</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural</u>	<u>5 1/2</u> years	OR TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR DISTRICT ADDRESS <u>District Training School</u>		STREET ADDRESS (If rural give location) <u>Laurel, Maryland</u>	
3. NAME OF DECEASED: (First) <u>Eleanor</u> (Middle) <u>Ann</u> (Last) <u>Toole</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Febr. 28</u> 19 <u>56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>1-19-36</u>
9. AGE last birthday <u>20</u> yrs.		IF UNDER 1 YEAR: Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Brice Toole, Deceased</u>		14. MOTHER'S MAIDEN NAME: <u>Eleanor Hibbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>3133 Connecticut Avenue, N.W.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Inanition</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Mental Retardation</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hydrocephalus</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-16</u> , 19 <u>56</u> , to <u>2-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-28-56</u> , 19 <u>56</u> , and that death occurred at <u>11:05</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Severitt T. Mahood</u>		ADDRESS <u>M. D. Laurel MD</u>	
DATE SIGNED <u>2/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 29 - 56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington, Virginia</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>28-28-1956</u>		REGISTRAR'S SIGNATURE <u>Wanda Houshup</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler &amp; Son, Inc., Wash., D. C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01352

1332

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>D.A. Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <i>10 Annapolis</i>		<i>2 or 3 days</i>		TOWN <i>Edgewater - md - X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>163 Anne Arundel General</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <i>Henry</i> (Middle) <i>Oliver</i> (Last) <i>Zucker</i>				<i>Feb. 16 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>male</i>	<i>white</i>	<i>WIDOWED</i>	<i>April 5, 1896</i>	<i>59</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>retired painter</i>		<i>painter</i>		<i>Friendship, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter Zucker</i>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>no</i>				<i>578-55-3203</i>		<i>Mrs Marie Robertson, Edgewater Md.</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>422.1 coronary occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>coronary arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 13</i> , 19 <i>56</i> , to <i>Feb. 16</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Feb. 15</i> , 19 <i>56</i> , and that death occurred at <i>9:30 a.m.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Emily H. Wilson</i> M.D.				ADDRESS (Street, city, town, state) <i>Lathen, Md.</i>		DATE SIGNED <i>2/16/56</i> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>2/18/56</i>		<i>2/18/56</i>		<i>Fort Lincoln Cem.</i>		<i>Columbia Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Feb. 18, 1956</i>		<i>U. Daniel</i>		<i>G. William Xees</i>		<i>20-4 3rd St. N.E.</i>	



## 1333 CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Annapolis</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		STREET ADDRESS		STREET ADDRESS	
57 <u>USNH, Annapolis, Md.</u>		<u>18 Spaview Avenue</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>William Anderson WENKER, Jr.</u>				<u>February 20 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>M</u>	<u>Cau.</u>	<u>S</u>	<u>16 February 1956</u>		<u>4</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
				<u>Maryland</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William A. WENKER</u>				<u>Joan Wainright GASSNER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<u>-</u>		<u>U.S. Naval Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>756.2 IMMEDIATE CAUSE (A)</b> <u>Aspiration Pneumonia</u> <u>#763</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Acute peritonitis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Atresia of small intestine</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2-16</u>, 19 <u>56</u>, to <u>2-20</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>2-20</u>, 19 <u>56</u>, and that death occurred at <u>11:45 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>E.R. PETERS LCDR MC USN</u>				<b>DATE SIGNED</b> <u>21 FEB. 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>				<b>DATE THEREOF</b> <u>2/23/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>U.S. NAVAL ACADEMY</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>John M. Taylor</u>		<u>John M. Taylor</u>		<u>John M. Taylor</u>		<u>Annapolis, Md.</u>	
<b>DATE</b> <u>2/23/1956</u>		<u>2051 R 41365</u>					

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**AUTHOR:**

1960-1961

FEB 27 1961

100

DECEMBER

BUREAU V. S.

FEB 27 1956

RECEIVED

## INSTRUCTIONS

VS A15C 1-55 10M

# 1334 CERTIFICATE OF DEATH

21

Reg. Dist. No. 245

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cottage City	16X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convelesent Home		STREET ADDRESS 3718 40th Place,.	
3. NAME OF DECEASED (First) (Middle) (Last) India Williams		4. DATE OF DEATH (Month) (Day) (Year) February 12, 1956.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Nov 27, 1879
9. AGE last birthday 76 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John King		14. MOTHER'S MAIDEN NAME ? Hubble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS John G. Lowder Same as No 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)		18. MEDICAL CERTIFICATION Coronary Thrombosis Interoschial Heart Disease INTERVAL BETWEEN ONSET AND DEATH 2 HRS. in room	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/12, 1956, to 2/12, 1956, that I last saw the deceased alive on 2/12, 1956, and that death occurred at 8 AM, from the causes and on the date stated above. SIGNATURE Edward J. Beck M.D. ADDRESS (Street, city, town, state) 4400 Hyattsville Rd. Annapolis 2, Md. DATE SIGNED 2/14/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 15, 1956	
NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. REC'D BY REGISTRAR DATE Feb 14 1956		REGISTRAR'S SIGNATURE F Gasch's Sons Hyattsville, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. AGE		4. SEX	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF NOTARY		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF DEPUTY SHERIFF		22. SIGNATURE OF CONSTABLE	
23. SIGNATURE OF DEPUTY CONSTABLE		24. SIGNATURE OF JURY	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF CLERK	
27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF SHERIFF	
29. SIGNATURE OF DEPUTY SHERIFF		30. SIGNATURE OF CONSTABLE	
31. SIGNATURE OF DEPUTY CONSTABLE		32. SIGNATURE OF JURY	
33. SIGNATURE OF JUDGE		34. SIGNATURE OF CLERK	
35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF DEPUTY SHERIFF		38. SIGNATURE OF CONSTABLE	
39. SIGNATURE OF DEPUTY CONSTABLE		40. SIGNATURE OF JURY	
41. SIGNATURE OF JUDGE		42. SIGNATURE OF CLERK	
43. SIGNATURE OF REGISTRAR		44. SIGNATURE OF SHERIFF	
45. SIGNATURE OF DEPUTY SHERIFF		46. SIGNATURE OF CONSTABLE	
47. SIGNATURE OF DEPUTY CONSTABLE		48. SIGNATURE OF JURY	
49. SIGNATURE OF JUDGE		50. SIGNATURE OF CLERK	
51. SIGNATURE OF REGISTRAR		52. SIGNATURE OF SHERIFF	
53. SIGNATURE OF DEPUTY SHERIFF		54. SIGNATURE OF CONSTABLE	
55. SIGNATURE OF DEPUTY CONSTABLE		56. SIGNATURE OF JURY	
57. SIGNATURE OF JUDGE		58. SIGNATURE OF CLERK	
59. SIGNATURE OF REGISTRAR		60. SIGNATURE OF SHERIFF	
61. SIGNATURE OF DEPUTY SHERIFF		62. SIGNATURE OF CONSTABLE	
63. SIGNATURE OF DEPUTY CONSTABLE		64. SIGNATURE OF JURY	
65. SIGNATURE OF JUDGE		66. SIGNATURE OF CLERK	
67. SIGNATURE OF REGISTRAR		68. SIGNATURE OF SHERIFF	
69. SIGNATURE OF DEPUTY SHERIFF		70. SIGNATURE OF CONSTABLE	
71. SIGNATURE OF DEPUTY CONSTABLE		72. SIGNATURE OF JURY	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF CLERK	
75. SIGNATURE OF REGISTRAR		76. SIGNATURE OF SHERIFF	
77. SIGNATURE OF DEPUTY SHERIFF		78. SIGNATURE OF CONSTABLE	
79. SIGNATURE OF DEPUTY CONSTABLE		80. SIGNATURE OF JURY	
81. SIGNATURE OF JUDGE		82. SIGNATURE OF CLERK	
83. SIGNATURE OF REGISTRAR		84. SIGNATURE OF SHERIFF	
85. SIGNATURE OF DEPUTY SHERIFF		86. SIGNATURE OF CONSTABLE	
87. SIGNATURE OF DEPUTY CONSTABLE		88. SIGNATURE OF JURY	
89. SIGNATURE OF JUDGE		90. SIGNATURE OF CLERK	
91. SIGNATURE OF REGISTRAR		92. SIGNATURE OF SHERIFF	
93. SIGNATURE OF DEPUTY SHERIFF		94. SIGNATURE OF CONSTABLE	
95. SIGNATURE OF DEPUTY CONSTABLE		96. SIGNATURE OF JURY	
97. SIGNATURE OF JUDGE		98. SIGNATURE OF CLERK	
99. SIGNATURE OF REGISTRAR		100. SIGNATURE OF SHERIFF	

NOTATION

1. If the deceased was a resident of the State of Maryland, the death must be reported to the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If the deceased was a non-resident of the State of Maryland, the death must be reported to the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If the deceased was a resident of the State of Maryland, the death must be reported to the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If the deceased was a non-resident of the State of Maryland, the death must be reported to the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death.

BUREAU V. S.

FEB 17 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01355

1379

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crownsville</b>		LENGTH OF STAY (in this place) <b>12yrs. 8mos. 9days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore City</b>		<b>3yrs. 1-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>10 Crownsville State Hospital</b>				STREET ADDRESS (If rural give location) <b>325 N. Gilmer Street</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mary Williams</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>2 5 19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Unknown</b>		<b>9. AGE last birthday</b> <b>57 1/2 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>- - -</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>	
<b>13. FATHER'S NAME</b> <b>Henderson Harris</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Florence Powell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Hospital Records</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>171X IMMEDIATE CAUSE (A)</b> <b>Secondary Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Ca of Cervix</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>- -</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>- - - - -</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <b>M. 11:00</b>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>1/21</b> , 19 <b>48</b> , to <b>2/5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/5</b> , 19 <b>56</b> , and that death occurred at <b>5:00 a.m.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>L. Benedict</i> (L. Benedict, M. D.) M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>Crownsville, Md.</b>		<b>DATE SIGNED</b> <b>2/5/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>REMOVED</b>		<b>DATE THEREOF</b> <b>Feb 13-56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wofm Med School Green St.</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>24. REC'D BY REGISTRAR</b> <b>FEB 13 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <i>L. M. Joyce</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>D. J. P. Bros.</i>		<b>ADDRESS</b>	
<b>DATE</b>							

# CERTIFICATE OF DEATH

1218

NAME OF DECEASED ANNIE A. [illegible]		AGE [illegible]		SEX F		RACE W		DATE OF BIRTH [illegible]		PLACE OF BIRTH [illegible]	
RESIDENCE [illegible]		OCCUPATION [illegible]		CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]		DATE OF DEATH [illegible]		PLACE OF DEATH [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF CORONER [illegible]		SIGNATURE OF DECEASED [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]	

BUREAU V. S.

FEB 16 1936

RECEIVED

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This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the place where the death occurred. It is to be filled out in duplicate, one copy to be retained in the office of the Registrar and the other copy to be sent to the local health officer.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01356

## 1380-CERTIFICATE OF DEATH

Items 12 25 FilmG193 2-28-56 et

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>MILLERSVILLE</u>		<u>2 WEEKS</u>		TOWN <u>FERNDAL - GLEN BURNIE POx</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SANN'S NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>111 FERNDAL ROAD</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOSEPH</u> (First) <u>WITKOWSKY</u> (Last)				<b>4. DATE OF DEATH</b> <u>FEB 13</u> (Month) <u>13</u> (Day) <u>1956</u> (Year)			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 3, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOULDER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O. RR</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> ✓	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MR. John Rickert</u>		<u>111 Ferndale Rd. Ferndale, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>General Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Pneumonia</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/11/56</u> <b>to</b> <u>2/13/56</u> <b>that I last saw the deceased</b> <b>alive on</b> <u>2/13/56</u> <b>and that death occurred at</b> <u>11 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>John Rickert</u> <b>ADDRESS</b> (Street, city, town, state) <u>Glen Burnie, Md.</u> <b>DATE SIGNED</b> <u>2/10/56</u> <u>M.D. Glen Burnie, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM.</u>		LOCATION (City, town, or county) <u>DUNDALK - BALTO. CO MD</u> (State)	
24. REC'D BY REGISTRAR <u>FEB 21 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home, Glen Burnie, Md.</u> ADDRESS			

# 1936 CERTIFICATE OF DEATH

REG. NO. 10

1. PLACE OF DEATH

HOME

1000 N. E. ST.

BALTIMORE, MD.

1000 N. E. ST.

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BALTIMORE, MD.

BUREAU V. S.

FEB 21 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01357

1335

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Shedyside</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EFFIE</u> (Middle) <u>MOORE</u> (Last) <u>WOOLVERTON</u>				(Month) <u>Feb</u> (Day) <u>21</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Oct 24 1876</u>	<u>79</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Post Clerk</u>		<u>Clerical</u>		<u>Mississippi</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Sidney Woolverton</u>				<u>Fannie Lee Tolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>CHAS. E. BALDWIN JR</u> <u>2803 Blaine Dr Chevy Chase Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.1 IMMEDIATE CAUSE (A) <u>Chronic Myelogenous Leukemia</u>				<u>3<sup>+</sup> yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>2</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/24/53</u> , to <u>2/21/56</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>56</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Frank M. Shively</u>				<u>Annapolis, Md</u>		<u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Entombment</u>		<u>2/23/56</u>		<u>Fort Lincoln</u>		<u>Washington D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FILED</u>		<u>Wm. J. French</u>		<u>Bernard Hardisty</u>		<u>Galesville Md</u>	
DATE <u>24 1956</u>							



## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1381 **CERTIFICATE OF DEATH**

01358

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<input checked="" type="checkbox"/> TOWN <u>Millersville &amp; Rural</u>				<u>Elvaton, Millersville PO,</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Frederick H. Zick</u>				<u>2/1/</u> 19 <u>56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 16, 1883</u>	<u>72</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Butcher</u>		<u>Meat Market</u>		<u>Baltimore, Md.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Henry F. Zick</u>				<u>Barbara Trump</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>none</u>		<u>Mrs Viola Zick, Elvaton, Pasadena, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Disease</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 25, 1955</u>, to <u>Feb 1, 1955</u>, that I last saw the deceased alive on <u>Feb 1, 1955</u>, and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James S. Bellingslee</u>				<b>ADDRESS (Street, city, town, state)</b> <u>108 Contant Ave. Glen Burnie Md 742192</u>			
<b>DATE</b> <u>Feb 3, 1956</u>				<b>DATE SIGNED</b> <u>James S. Bellingslee</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>1/5/56</u>		<u>Glen Haven Memorial</u>		<u>Glen Burnie, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
		<u>L. J. DeAlba</u>		<u>James S. Bellingslee</u>			
				<b>ADDRESS</b> <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

# CERTIFICATE OF DEATH

1931

11338

Reg. Dist. No.

NAME OF DECEASED

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

AGE  
SEX  
RACE  
BIRTH DATE  
BIRTH PLACE  
EDUCATION  
OCCUPATION  
MARRIAGE

RESIDENCE  
PREVIOUS RESIDENCE  
EDUCATION  
OCCUPATION  
MARRIAGE

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

RESIDENCE  
PREVIOUS RESIDENCE  
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OCCUPATION  
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PREVIOUS RESIDENCE  
EDUCATION  
OCCUPATION  
MARRIAGE

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

BUREAU V. S.

FEB 6 1931

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1382  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film 192-2-20-56 et  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01359

Reg. Dist.

No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>D.C.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN				TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Cat-Tail Creek, Tributary Stream of Magothy River</u>		STREET ADDRESS (If rural, give location) <u>Box 356-A, Magothy Road</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH			
(Type or Print)		<u>Otto Karl Zwanzig</u>		2 9 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>May 10, 1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Retired</u>		<u>Germany</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Karl Zwanzig</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS			
<u>no</u>		<u>217-32-8957</u>		<u>1325 N. Linwood Ave Mrs Frieda Hylla, Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Drowning</u>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dissecting Aortic Aneurysm</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY?
							Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Creek</u>		21c. (City or town) (County) (State)			
				<u>Anne Arundel Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2 9 56 3:45 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in Water</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Thurkmen</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/10/56</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/13/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 13, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		24. FUNERAL DIRECTOR <u>Hopping and Kirkley, Glen Burnie, Md.</u>		ADDRESS	

BUREAU V. S.

FEB 14 1966

RECEIVED